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ABSTRACT

Thousands of children exposed prenatally to drugs are now of school age, presenting schools and educators as well as social service agencies with enormous challenges. This book provides information from education, medical, public health, and social service experts on the degree of damage these children have sustained, whether that damage will be long-term, and what interventions can help them grow into healthy, contributing citizens. It includes research findings, model school and clinic-based programs, and an agenda for action. Following an introduction by Allan Shedlin, Jr., the articles are: (1) "Prenatal Exposure within the Context of Children in Today's Society" (Kati Haycock); (2) "Myths and Realities: What Do We Really Know about the Effects of Prenatal Exposure to Drugs and Alcohol?" (Deborah Frank); (3) "Recognizing the Meaning of Motherhood for Women in Treatment and Recovery" (Michele Shedlin); (4) "Some Observations from the Front Lines" (Rachelle Tyler) a pediatrician's view of the social needs of drug-exposed children; (5) "A Framework for Evaluating Children Prenatally Exposed to Crack" (Steven Merahn); (6) "Project Daisy: A Regular Education Project for Children Prenatally Exposed to Drugs and Alcohol" (Diane Powell); (7) "Project Healthy Choices: Building Stronger Voices" (Eileen Wasow and others); (8) "The Women and Infants Program: The Family in Focus" (Kathleen Fitzgerald); (9) "Reframing the Debate," on the need to shift away from the "victim" mentality (Mark Rapoport); and (10) "Stop the Research, Start the Work" (Eric Brettschneider). (TJQ)

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NEITHER DAMNED NOR DOOMED:

EDUCATING CHILDREN PRENATALLY EXPOSED TO DRUGS & ALCOHOL

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- Research Findings
- Model School and Clinic-based Programs
- An Agenda for Action

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Elementary School Center
Edited and produced by Alan Shedlin, Jr., Executive Director

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NEITHER DAMNED NOR DOOMED:

EDUCATING CHILDREN PRENATALLY EXPOSED TO DRUGS & ALCOHOL

Edited with an Introduction by Allan Shedlin, Jr., Executive Director

esc
Elementary School Center

Dedicated to
THESE CHILDREN/OUR CHILDREN
and their families

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The Elementary School Center is a national advocacy, policy, and resource center. The mission of the Elementary School Center is to promote optimal learning and development for every elementary school child by assuring that every child comes to school ready to learn every day and that every school is prepared to teach every child.

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PREFACE

This book contains information from educators, medical, public health, early childhood, and social service experts presented at the Elementary School Center's Institute, ***EDUCATING CHILDREN FROM THE WORLD OF CRACK: Realities & Myths Concerning Children Prenatally Exposed to Drugs & Alcohol***. It also features an Agenda for Action, developed during the Institute.

Held at the New York Academy of Medicine, ESC's interdisciplinary Institute was cosponsored by:

- The New York City Department of Health
- The New York City Public Schools
- The Resource Access Project, Department of Human Services and Education, New York University
- The United States Public Health Service, Region II
- The Westchester County War On Drugs
- The Training Center for Health Professionals

The Institute was made possible in part by the generous support of *Hasbro Children's Foundation* and *The Hitachi Foundation*.

INTRODUCTION

All our children are growing up in a world "at risk." Those children whom we have traditionally labelled "at risk" are now more aptly labelled "in trouble." Many of our schools are in a precarious state, especially those in urban areas of concentrated poverty. Any additional burden at this time of shrinking budgets and increasing class sizes could be the straw that breaks the camel's back for many teachers and schools.

Professionals who serve children — pediatricians, nurses, regular and special education teachers, social workers, child welfare experts, nutritionists, speech pathologists, Head Start and child care teachers — are all deeply concerned about the influx of drug-and alcohol-exposed children in our nation's schools. Furthermore, this issue has been of great interest to foundation officers, policy analysts, college professors and deans, and all levels of government officials, including policymakers.

Concerned professionals such as these came together at the Elementary School Center (ESC) to work on this problem. Together, we have developed the materials in this book. The Center has also produced two videos and a compilation of background readings on this topic. Our colleagues have relied upon ESC to make this information available to others who so desperately need it. We all want to understand and respond better to the needs of THESE CHILDREN/OUR CHILDREN. We all need solid knowledge upon which to base informed decisions and set realistic, effective policies.

Until recently, concerned professionals have had little to go by, other than the often hysterical coverage found in the news media. Little was available about the findings of serious researchers or the experiences of dedicated professionals who were already dealing with the problem by setting up programs and working with individual children, their families, and their schools.

We learned much from each other:

- The problems of drug-affected children must often be viewed in the context of drug-using and-abusing families and communities. THESE CHILDREN'S problems cannot be viewed in isolation but rather as a part of the new social realities of the "world of crack."
- Drug addiction does not discriminate. Drug and alcohol abuse occurs across the entire socio-economic, racial, ethnic, and geographic spectrum.

- We need human support across disciplinary lines and we need increased resources to help THESE CHILDREN.
- There are clear implications for preventive measures. The conditions which drive people to abuse drugs and alcohol in the first place make their children acutely vulnerable to a whole range of problems which often preclude their getting the most out of school.

This book, in addition to ESC's compilation of background readings, *EDUCATING CHILDREN FROM THE WORLD OF CRACK: Realities & Myths Concerning Children Prenatally Exposed to Drugs & Alcohol,* and our two videos, which feature mothers and teachers of children exposed to drugs and alcohol, offers solid information on the problems of how to educate children prenatally exposed to drugs and alcohol. The book also demonstrates clearly that THESE CHILDREN/OUR CHILDREN need be NEITHER DAMNED NOR DOOMED.

The information in this book is important. By calling our attention to a particularly vulnerable group of children, families, and caregivers, it can in turn address the needs of a much broader spectrum of individuals who are also growing up in a world at risk.

Our sincere thanks to all of the contributors. Their names and titles appear on each piece. For those who wish further information, their addresses also appear in the appendix.

Because the Elementary School Center believes that those most directly affected by policy decisions must be heard when determining such policies, we have spent time listening to mothers in recovery as well as to teachers who are on the front lines. Their voices — like those of a Greek chorus — appear throughout this document.

Thanks, too, to all the caring professionals who contributed their best thinking and hard work, helping the Elementary School Center develop materials on THESE CHILDREN, who are really OUR CHILDREN, who are more *like* other children than different from them, and who must be seen first as children and second as a generation bearing the consequences of the poverty, neglect, ignorance, and violence in the lives of their families.

New York, New York
July 1992

Allan Shedlin, Jr.
Executive Director
Elementary School Center

Prenatal Exposure Within the Context of Children in Today's Society

Kati Haycock, M.A.
Director, The Education Roundtable
Former Vice President, Children's Defense Fund

There has been a lot of attention given to children this year. Due in large part to the first World Summit on Children held at the United Nations in New York City, there has been a great deal of media coverage of children in need. As a result, we have learned much more than we ever knew before about malnutrition and starvation in Africa and about the desperate plight of children in war torn nations like El Salvador and Iraq.

What many people fail to realize, however, is that within our midst, there are literally millions of American children growing up in circumstances every bit as deplorable as those in any Third World nation.

Some Simple Facts

The facts on children in the United States are simple and sobering. The number of children, soon to be young adults, in our society is dwindling. In the year 2000, there will be approximately 5.5 million fewer young Americans between the ages of 18 and 24 than there were in 1980 — and millions more senior citizens for them to support. This means that we need to prepare each child, including the growing number who are poor or ethnic minorities, to be fully productive — if our nation is to thrive.

But the ability of the United States to compete — much less to innovate and lead — is being subverted by the intolerable conditions that we are inflicting on those who we need to be our future leaders, workers, parents and innovators: our children.

- One in five American children, more than 12 million in all, are currently growing up in poverty. Children are by far the poorest Americans — more than twice as poor as any other age group — and they grew poorer during the 1980s while our nation grew richer.
- About one in five American children has no health insurance. Among industrialized nations worldwide, only the United States and South Africa fail to provide a decent floor of health coverage for all women and children.
- And while the United Nations International Children's Emergency Fund (UNICEF), as many of you know, has waged a wonderfully effective childhood immunization campaign worldwide, United States immunization rates have declined and incidents of preventable disease have risen at an incredible rate over the last few years. Nonwhite one-year-olds in our country are now

less likely to be fully immunized against polio than are children in 47 other countries, including Botswana, Sri Lanka, Albania and Colombia.

- Young families, on whom all of us count to raise healthy children for America's future, are in extraordinary trouble. Since the early 1970s, they have suffered a frightening cycle of plummeting earnings, declining numbers of marriages, a near doubling of birth rates among unmarried women, falling incomes and skyrocketing poverty rates.

In the fall of 1989, when then Solidarity leader Lech Walesa visited Washington, D.C., he told a group of U. S. Senators, "Please take care of your country, for who is going to lead us if not you?" But the fact is — and all of you know this — we have not been taking care of our country, its children, its natural resources, its human resources or its ideals, and we are endangering our ability to lead. If we want to lead, we absolutely can not continue to neglect our most vulnerable citizens or our economic and moral underpinnings.

Begin With Families

Reaffirmation and renewal of our country must begin with strengthening America's families, in all of their present configurations. Parents and family are the cornerstones of any child's life. All children need strong families that can provide them with the basics for survival, as well as with love, security, proper values and a sense of home and safety. But as all of you know all too well, many children in all ethnic groups and all economic groups do not have strong families now. Our society has to do a much better job than it is at the moment of preparing young people to parent, of helping teens who are not yet ready to parent to avoid early pregnancy, and of sending strong cultural messages that parenting is serious business.

The more safe, secure and stable families are, the better able they will be to provide what their children need and to start them on a path of high achievement. Therefore, the first imperative for all sectors of our society is to insure that families have what they need to thrive-both for their own sakes and for the sake of their children.

Next, Meeting Basic Needs

The second imperative is to insure that we meet the basic needs of all of our children for health care, child care, shelter and nutrition so that they will be prepared to achieve in school. A child with an undiagnosed vision problem or without the means to purchase glasses once a problem has been diagnosed will not achieve his or her potential. Similarly, a child whose intellectual development is stunted by exposure to lead will not do as well in the classroom. And children who are "warehoused"— who are parked through the first three years of their life in poor quality child care centers and lined up in front of televisions - are not going to enter school with as many skills as children who have the advantage of a high-quality child-development program.

Improve Our Schools

The third imperative is to improve our public schools vastly, especially the schools that serve poor and minority children. Although these children enter school only slightly behind other youngsters on any test of achievement used, the gap that separates them from other young Americans grows dramatically as they progress through the grades. By third grade, the average African-American or Latino student in this country is already about six months behind. By the sixth grade, they are about one year behind; by the eighth grade, they are about two years behind; and by twelfth grade (if they reach twelfth grade at all), the average African-American or Latino youngster performs more than three grade levels below his Anglo peers. In fact, accord-

Reaffirmation and renewal of our country must begin with strengthening America's families, in all of their present configurations.

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ing to the most recent data available from the National Assessment for Educational Progress, the average African-American or Latino seventeen-year-old in this country has skills in English, in mathematics, and in science about the same as the average white thirteen-year-old.

When presented honestly — and they very seldom are — these data can be discouraging and overwhelming. They can lead either to a sense of paralysis or to some soul-wrenching questions about whether these youngsters really can learn. But the fact is that across this country, there are schools that are proving every single day of the school year that minority and poor students can achieve at the same high levels as anybody else if they are taught at the highest levels and provided with the help that they need to get there.

Unfortunately, far too few minority and poor students are being educated with this kind of challenge. Instead, most of them spend their days in boring classrooms circling M's and P's on ditto after ditto. Very little of any real interest or content is made available to them.

In fact, although nobody likes to talk about this very much because it flies in the face of everything that we like to believe about ourselves as a nation, these youngsters get less of everything that we believe makes a difference. They get less in the way of experienced and well-trained teachers. They get less in the way of a rich and well-balanced curriculum. They get less actual instructional time, less in the way of well-equipped and well-stocked laboratories and libraries, and less of what undoubtedly makes the very biggest difference of all, and that is a belief that they can really learn.

How does this happen in what we think of as our single system of public education in this country? It happens primarily in two ways. First, the differences between the schools that serve minority and poor children, and those that serve other children are profound and unsettling. Secondly, the differences within schools between what goes on in so-called high-track classes and what goes on in all the rest are destructive and elitist.

In the first case, despite what we thought had happened with *Brown vs. Board of Education* and the many desegregation decisions that followed it, most poor and minority children in this country are still educated separately from other youngsters, and their schools tend to get the least well-trained teachers and the lowest level curricular materials. Virtually everything is watered down. For youngsters who we do

not manage to "get" in this way, we have another practice: it is called "ability grouping" and "tracking" and it has essentially the same effect. In general, we herd poor and minority youngsters into low-track classes, where we assign them our worst teachers, our oldest books and then expect essentially nothing from them. It is hardly surprising, then, that minority and poor students do less well on standardized tests — because the fact of the matter is that we teach them a good deal less.

As if all of this were not enough, though, some *communities* have less too. Less knowledge about how schools work, fewer skills to help with homework, less flexible time to visit schools, fewer resources to pay for educational extras, and hopes and dreams for children that are all too often simply overwhelmed by the day-to-day business of survival, especially in today's cities.

The combination of these two factors, both the problems in our schools and the problems in some communities, are devastating for poor and minority youngsters. Most are nowhere near mastering the kinds of knowledge and skills that they need to have and that we need for them to have. And how sadly ironic that things should be going from bad to worse just at a time when our economy promises finally to soon produce the kinds of jobs that will be capable of lifting people permanently out of lives of poverty.

Some Sobering Statistics

Look with me for a moment at what happens to children in America every day and think about what these numbers mean for our collective future.

Every Day in America

- 2,740 teenagers get pregnant
- 1,105 teenagers have abortions
- 1,293 teenage girls give birth
- 700 babies are born at low birthweight
- 69 babies die before one month of life
- 107 babies die before their first birthday
- 27 children die from poverty
- 9 children die from guns
- 6 teenagers commit suicide
- 1,375 American teenagers drop out of school
- 1,849 children are abused
- 3,288 children run away from home
- 2,407 children are born out of wedlock
- 2,987 children see their parents divorced
- 135,000 American children arrive at school with a gun.

What Can We Do?

The question, of course, is what can we do? One of the most corrosive developments of the 1980s was the propagation of a belief that we cannot do anything about those numbers. We were told that nothing works; that we cannot make a difference; that all efforts to ameliorate problems were destined to fail; that teaching and other forms of public service were considered unworthy callings. People began to withdraw from engagement in public life and lead their lives in ever-smaller circles. It sometimes seems as though our entire nation has been buried in one of those spirit-squelching, hope-destroying schools in which we bury so many of our children.

Told that in public life we did not have the ability to perform, we stopped trying. Told that as a nation we could not achieve social reform, we gave up the effort. These teachings have poisoned public life in this country and contributed to a widespread sense of despair about our ability to mend this nation's very seriously torn social fabric.

But the fact is that the lessons we were taught in this national schoolroom of the 1980s were dead wrong.

Our nation, as all of you know, has made real gains when it has paid attention to how we as individuals, as well as to how we acting collectively through government, can help

The differences between the schools that serve minority and poor children and those that serve other children are profound and unsettling.

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families and neighborhoods to thrive. It is vitally important that all of us let our friends, our colleagues and our political leaders know that some things do work: that early investment, for example, is always cheaper than ignorance, unemployment and later dependency; that schools with strong leadership, a demanding curriculum and a caring staff absolutely can raise student achievement levels; that when we as a society really tried, we did in fact affect real reductions in infant mortality, in low birthweight, in childhood illness, and school dropouts. We achieved real gains in academic achievement, in college attendance, in health status and longevity.

All of this is no mystery. It is simply common sense. We do need to learn more. We do not yet know all of the answers. But we also need to discard simple-minded sloganeering and do more of what all of us know really works.

It is also important that we reject the despair that comes from a false belief that our society does not have the resources to solve its problems. There is a widespread sense around this country that America is somehow poorer now than we were 10 or 20 years ago and that we cannot afford any major social undertaking. This is nonsense. A country that is poor and truly cannot afford to tackle its problems and nurture its children is doomed to decline because of its bankruptcy. But a wealthy country that lacks the will to solve its problems but excuses itself by saying that the cost is too high is doomed to decline because of its moral bankruptcy.

We do not lack the resources. America's Gross National Product is still by far the largest in the world. But although our Gross National Product is the largest and our per capita GNP the second largest in the world, we do not rank even in the top ten on any indicator of our care for our children. In infant mortality, the United States currently ranks twentieth in the world; and in mortality of children below the age of five, we rank twentysecond in the world; in the proportion of our children born at low birthweight, we rank nineteenth in the world; in the proportion of our children fully immunized, we rank fifteenth in the world; in the ratio of teachers to children, we rank nineteenth in the world; in the proportion of our children we allow to live in poverty, we rank at the bottom among industrialized nations; in math and science achievement, as all of you know, we rank near the bottom among industrialized nations; in the proportion of our teenage girls who get pregnant, we rank at the bottom

*The fact is that we **can** afford investing in our children. And if we do not, we will pay a much higher price later on.*

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amongst industrialized nations.

The fact is that we *can* afford investing in our children. And if we do not, we will pay a much higher price later on.

Making Better Choices

So where do we begin? Everyday — although most often subconsciously — each of us makes a series of choices. I have discussed some of the choices our government has made. But the fact is that the welfare of children is affected by other choices as well. Choices we make as parents and grandparents. Choices we make as neighbors, church and club members. Choices we make as professionals. And choices we make as citizens in the messages that we send to our government. It is time that all of us looked hard at all of those choices and time that we put children first instead of last.

We start this process, I think, in our own homes and in our own neighborhoods. All of us must ask ourselves what our own lifestyles are telling our children, our grandchildren, our nieces and nephews and our neighbors' children. We want them to read, to learn, to do homework, to limit their TV-watching, to be honest, not to use drugs and alcohol, and to be compassionate, engaged and respectful of others. If that is what we want, we need to make sure that we are doing our best to live lives that set that kind of example.

As the forces of economic, social and cultural change whirl ever faster in this country, spinning so many vulnerable families away from their moorings and ripping them apart, it is more essential than ever before that we parents keep our bearings, that we get our own houses in order, and that we set clear limits for our children. We have to transmit clearly the proper values to our children because modern society has empowered so many outside cultural competitors to teach them a whole different set of values. Second, we can and we must add our voices to others who are pressing government for strategic investments in children. Investments that will indeed cost us something more in the short term but will save huge amounts later on. Prenatal care for poor women, for example, saves both lives and dollars. Approximately three dollars in later costs are saved for every one dollar we invest. Yet many needy women still do not have access to quality prenatal care. Nutrition supplements also save lives and dollars, again about three dollars in later costs saved for every one additional dollar we invest. Yet 40 percent of poor women and children in this country still do not have access to nutrition supplements. Head Start programs also save dol-

lars and help to assure this country a more competitive future. But Head Start programs still only reach about one in four of the children who meet program requirements.

Finally, we must improve our public schools, especially those serving minority and poor students. Instead of continuing to tack on special programs to the outside of our schools and expecting them to compensate in 30 minutes a day or a couple of hours a week for the effects of poor instruction the rest of the school day and school year, we must systematically fix whole schools. Instead of watering down what we teach, we must systematically beef it up. Instead of expecting less, we must systematically expect more. We must, in short, educate all of our students, every single one of them, in ways that used to be reserved for the chosen few.

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"I had my daughter when I was 18. I was a baby having a baby. I didn't know anything about taking care of children. I didn't know who to turn to or who to talk to about things that was going on inside of me. And I was afraid to talk to my mother. So what did I do? I turned to the streets."
Tanya, mother

"The only way that teacher is going to know what's going on is by me going up there and breaking my anonymity. My children have abandonment issues. How are they supposed to know the reason he's not doing good right now is because he's got a fear of being left?"
Cathy, mother

Myths and Realities: What Do We Really Know about the Effects of Prenatal Exposure to Drugs and Alcohol?

Deborah Frank, M.D.
Director, Growth & Development Program
Boston City Hospital

There is a drug that many pregnant women in the United States use regardless of the well-documented harm it can cause to a developing fetus. This drug restricts the flow of oxygen to the fetus, increases the risk of spontaneous abortion, stillbirth and sudden infant death syndrome, and decreases the baby's size at birth. Children who are exposed to this drug are permanently deficient in height; they have attention deficits, neurologic soft signs; and at school age they have lower IQs and problems with reading and — in particular — math. This drug is so potent that just being in the same room with somebody who is using it during pregnancy — not being a user yourself but being surrounded by fumes — can be noted in your child at age seven. Children who are passively exposed have depressed speech and language scores, distractibility and behavior problems.

With this information, would you adopt or counsel a family member to adopt a child who was exposed to this drug in the womb? And what do you think — there has been massive publicity about this drug — should happen to a woman who uses this drug during pregnancy? Should she be sterilized? Should she be put in prison? Should her children be taken away?

The drug I described is tobacco-nicotine in the form of cigarettes. A billion dollars is made illegally every year simply by selling this drug to minors. The people who make this money are respectable stalwarts of our national structure. What amount of responsibility do the people who push cigarettes and alcohol on our population and who object violently to its taxation in any way commensurate with its social damage need to accept for the damage done to our children?

I was a cigarette-exposed child, and I have deficits. I am short. In elementary school I was never sent to take a message to the office because I got lost in the hallways. I failed handwriting every year it was graded. But my teachers did not say, "Oh, my God. A cigarette-exposed child in our classroom." They said, "This is Debbie. She is very good at some things and she is awful at other things.

We will work on what she is not so good at and we will push along on what she can do." My first report card said, "Lovely grace at milk and cookies. Cannot cut with scissors."

Is the Child Half Empty or Half Full?

How you approach a problem is critically important to how that problem will be resolved. So while my teachers were well aware of my deficits they always looked for my strengths as well. In contrast to this approach, an article published several years ago in *Rolling Stone* magazine asserts, "Babies born to crack addicted mothers are like no others. Brain damaged in ways yet unknown, they're oblivious to any affection. How do you care for a baby who hates to be held?"

This approach to the problem of children prenatally exposed to drugs is not only untrue, it is not useful. But this is the sort of approach which is shaping our expectations of the prenatally drug-exposed children who are entering our classrooms.

In a study conducted and published by Rosenthal called "Pygmalion in the Classroom," a group of children in a low to middle class school in Ohio were selected. Of this group, ten percent of the students in each class were randomly singled out and their teachers were told that these ten percent were "late bloomers" — they were going to have an intellectual leap over the coming school year. And 47 percent of those students, compared to 19 percent of the control students, gained 20 or more IQ points in the course of the year just on the basis of teacher expectations.

The Plight of the Dumb Rat

Expectations for behavior can serve as a self-fulfilling prophecy in research settings as well as in the classroom. Rosenthal and Jacobson went on to study researchers and found that their expectations could influence the outcome of their findings. For those who teach fifth and sixth grade science, I recommend the following experiment: take two genetically identical rats from the same litter, create a maze and tell your students that one rat is intelligent and the other is dumb. Select which rat is "smart" by the flip of a coin. Amazingly, the "smart" rat will in fact run the maze much better than the "dumb" rat because of the positive reinforcement it will receive from the students.

Much like the predicament of the "dumb" rat, cocaine-exposed infants are strongly jeopardized by negative expectations. We must learn to change the way we look at these children in order to help them perform at their peak. All developmental assessments of cocaine-exposed children should be conducted blind to history because even the most sensitive examiner will approach a child he is told has recurring ear infections with different expectations from a child who he is told had *in utero* cocaine exposure.

The Problems of Identifying Drug-Exposed Children

Identification of drug-exposed babies through laboratory testing is not a precise science either. Most infants are tested for prenatal drug exposure through their urine, and although a urinalysis is generally reliable, it can only detect cocaine that has been in the body for less than 72 hours. Because of this, most of the babies

who are identified through their urine were exposed very late in pregnancy and the mothers of these children are probably the heaviest users. There is however, a tendency to extrapolate from these heavily-exposed babies to what drug exposure may mean for all babies ever exposed.

In a sample of 1226 women taken at Boston University Hospital, all of whom were in prenatal care — which then is not representative of women who do not go to prenatal care — only six percent of users took drugs within seven days of delivery. So only this six percent would have been identified by the methods that are usually reported in the literature. And only one-fifth of these users took drugs more than three times a week.

Identification through hair testing is even less reliable a gauge of exposure. Hair is confounded by environmental contamination and cosmetic applications, and there is no standardization of the labs that conduct this test. It is a totally inappropriate measure.

Currently, the most interesting medium for testing is meconium — the baby's first stool. It reflects the contents of the fluid surrounding the baby from about 18 weeks to gestation. This provides a cumulative measure of exposure right through pregnancy — a much longer window than urine. Meconium may actually begin to answer cumulative dose questions not only for cocaine but for marijuana, opium and a lot of other drugs. Even meconium, however, can not tell at what point in the pregnancy a drug was taken, and this information is crucial to developmental outcome.

As an alternative or supplement to testing, identification is also made by asking the mothers whether they used drugs during their pregnancy. But the more our nation's attitude towards drug-abusing mothers becomes punitive and hysterical, the less these mothers will reveal. And even self-reporting can be unconsciously biased. If a group of parents of damaged children is asked whether they used any drugs during pregnancy and the same question is asked of parents with non-damaged children, there will most likely be a higher rate of self-reporting among the parents of damaged children. Parents who have children with damage tend to recall more and do more soul searching than parents whose children seem fine. If your baby has a problem, you may remember that you rode a motorcycle in your third month of pregnancy, while a mother with a healthy child may not remember that same information.

In addition to the technological limitations of testing and the shortcomings of self-reporting, there is tremendous ethnic and socio-economic bias in the ascertainment of drug use in pregnancy. African-American and/or poor people are much more likely to be identified clinically. Protective service reporting is also biased, because middle class mothers have an easier time hiding their use and are less likely to be questioned at all. All of these variables in the identification process make a credible national estimate of children prenatally exposed to drugs impossible. Estimates are done city by city. They are usually based on the population of inner-city hospitals. These regional estimates range anywhere from 3 percent to 20 percent of children tested showing signs of prenatal drug exposure.

In addition to the technological limitations of testing and the shortcomings of self-reporting, there is tremendous ethnic and socio-economic bias in the ascertainment of drug use in pregnancy.

But even the estimates we do have for the numbers of children who are being prenatally exposed to cocaine do not account for the tremendous variability in the timing and amount of this use during pregnancy. The physiologic variabilities of the mother and the fetus can also alter the effect of the drug. Furthermore, when illicit drugs are used, it is almost always impossible to be sure what substance contaminated the drug. Illegal drugs are often cut with strychnine or talcum. Illegal drug potency can also vary over time and from city to city, so that in almost all cases it is very difficult to get a pharmacological "handle" on what exactly may be affecting the fetus.

In most instances identification of cocaine use is most helpful as a marker for heavy exposure to everything else; people who use illegal drugs are also more likely to be heavy users of legal drugs. Twenty percent of all women use cigarettes during pregnancy and almost all women who smoke crack will also smoke cigarettes. Women who use cocaine are generally at risk for multiple biologic reasons because of their lifestyles, including infections and malnutrition as well as legal and illegal drug use. Because neonatal effects ascribed to cocaine may be caused by a number of pharmacologic exposures and biologic insufficiencies, there are few definitive facts about the ways in which cocaine exposure *in utero* affects an infant.

It is a known fact that cocaine constricts blood flow, which restricts both the delivery of oxygen and nutrients to the fetus. Cocaine may also affect the central nervous system, altering neurotransmitters and synapses, although this is not yet proven. There are rare, but physiologically plausible, catastrophes that are associated with cocaine such as placental abruption (the afterbirth coming away from the wall of the womb), strokes *in utero,* and stillborn babies.

Myths and Realities: The Intrauterine Effects of Cocaine Use and Low Birthweight

It has been shown by multiple researchers in multiple settings controlling for substances like cigarettes and alcohol, that cocaine exposure *in utero* is associated

with intrauterine growth retardation of birthweight, length, and head circumference. Cocaine is also associated with depressed body fat and muscle mass in babies. This is true even after controlling for maternal nutrition. Many babies whose parents come from a high-risk background are malnourished in the womb. Cocaine makes the babies hypermetabolic in the womb, so they use up calories as well as not getting the mother's calories because of constriction of the blood vessels. When these infants are born, they eat ravenously. This is very different from other babies with growth retardation because the post-neonatal growth of cocaine babies is quite good if they are immediately well cared for.

Mixed in with these facts are numerous hypotheses about cocaine-exposed children which are biologically plausible but not yet proven. Cocaine is associated with prematurity, and this relationship is often twisted by the popular press with photographs of infants wearing thick glasses, with braces on their feet and oxygen up their noses. The implication is that this is what cocaine does to babies, while in reality that is what low birthweight does to babies — and any number of biologic insults can cause low birthweight.

One of the controversies in the field of prenatal drug exposure is whether cocaine increases the severity of narcotic abstinence. When sensationalist media show an infant screeching and rubbing and crawling all over the bed this baby is withdrawing from narcotics and the mother may or may not have used cocaine at all. Babies exposed to cocaine, but not opiates, tend not to have a withdrawal syndrome. They are often medically indistinguishable from other babies and, if anything, their behavioral syndrome is that they are groggy and lethargic.

Another hypothesis — which is in fact very rare based on case reports — is that cocaine is associated with rare birth defects like kidney problems, heart problems, skull problems or limb problems. If you are working with a mother who is using cocaine, do not tell her that her baby will be born with missing arms and legs and will be a monster because of it. She will not believe you. Half of the children in her neighborhood were probably born while their mothers used cocaine and looked fine. The statistical likelihood is that her baby will also at least look fine. Instead, I tell these mothers that drug use is changing the odds against their baby — there is a greater chance that her child may have a problem.

Neonatal period cocaine exposure has also been associated with ultrasound identification of brain abnormalities. Ultrasound assesses the gross structure of the brain. These ultrasound abnormalities have gotten enormous press as proof that *in utero* cocaine exposure creates "babies with holes in their brains." In response to this scare, our hospital did a controlled study with half of the babies identified as cocaine-exposed through their meconium and half not-identified through their meconium. Their ultrasounds were given blind to a radiologist. The abnormality rates found were almost identical between the two groups. This is not yet published data, and it may change. But this information should make us question the enormous hype about ultrasounds as proof that these children are doomed

Despite the lack of solid information, it is hard for us not to anticipate problems from these children because of the pervasive myths that have irresponsibly surrounded this issue.

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forever. Because ultrasound technology is only several years old, and because the bleeds are usually found in areas that are clinically silent in infancy — the mid-brain — we also have no real idea of what the long-term implications of these findings may be.

Despite the lack of solid information, it is hard for us not to anticipate problems from these children because of the pervasive myths that have irresponsibly surrounded this issue. It is a myth that cocaine-exposed children are born addicted. They are not born addicted: there is no withdrawal syndrome, they do not have drug-seeking behavior, and they are not doomed to be adult addicts. The only genetics of addiction that has ever been illustrated in a scientifically credible fashion is from adult male alcoholic to adult male alcoholic. There is a clinical suspicion that there may be a genetic disposition to depression and anxiety which, if you were in a setting that encourages self-medication with drugs as a way to cope with this, may put a prenatally-exposed child at risk for addiction. But that is not even proven.

These children have been called a "bio-underclass": unlovable, unteachable, and almost all abnormal. This is based on almost no credible research. People do not use the same rhetoric with cigarette babies — "Their mother used drugs, now it's the children who suffer." Statements like this appear under the guise of compassion and caring, but it is really a very cynical attitude. It is a way of saying that this is an unsalvagable generation, that we do not need to put resources towards their plight, that it is all the parents' fault. That it has nothing to do with social choices. And there is a very narrow step from that attitude to the words of John Silber, the President of Boston University, who said of medical resources, "We shouldn't spend immense amounts on 'crack babies' who won't ever achieve the intellectual development to have the consciousness of God." Stigma becomes genocide. This is the leap that people are making, and it is becoming an excuse for writing off a generation of deprived children.

Whatever information research is uncovering, it certainly shows that prenatal

drug exposure is not a cookie-cutter syndrome even in infancy. The Brazelton Test is one way of looking at the range of developmental behaviors available to a baby for dealing with its environment that is often used to assess at-risk children. It is not an IQ test. I reviewed all the studies which used the Brazelton to assess infant development to see what commonalities in developmental outcome for prenatally drug-exposed infants they uncovered. In my review I only considered studies conducted by blind examiners. The babies in the study had not to have been opiate-exposed because narcotic abstinence syndrome can wipe out an infant's Brazelton scores, although neither the mother's opiate dose nor the severity of narcotic abstinence for the child has any predictive implications for developmental outcome. Each study also needed an adequate sample size of full-term babies.

Inaccuracies, Inconsistencies, and Doubts

Given all these specifications, research findings were nonetheless totally inconsistent from study to study. A study done by the National Association for Perinatal Addiction Research and Education (NAPARE) in Chicago found deficits in orientation — the baby's ability to look at objects, turn to a voice or turn to a ball. Researchers base their entire prediction of a child's social dysfunction on this orientation score in the Brazelton. The NAPARE study also found deficits in motor skills, state regulation and reflexes. A New York City study by Neuschfield did not find any problems at birth and at three weeks found some motor deficits but no other orientation abnormalities. These motor deficits were ultimately discounted when the infants were controlled for alcohol and other covariables statistically. A third study by Eisen in Florida (and this study will be published in *Pediatrics*) only found differences in habituation, which none of the other studies found.

Not only were the findings of these three studies varied, Dr. Brazelton himself would be the first to tell you that a single Brazelton in the first 72 hours of life is a poor predictor of later function. It tells you how the baby is at that moment and can provide helpful information for caregivers to know how to cope with the baby at that moment.

The Environment: Where the Risk Resides

It seems clear that the real risk for these children is the risk of their environment. I would spend a lot less time searching into the prenatal history of children at risk and a lot more time searching into their current environment to figure out what is wrong. Tovie Rosen did a study in New York City where she followed a group of opiate-exposed children through age four. She found that the children who — in their infancy — had kept her up at night in the nursery were not necessarily the ones who looked awful later on. The children who looked awful were the ones who were currently in drug-using environments.

One major postnatal risk for cocaine-exposed children is on-going pharmacologic exposure to the drug. Cocaine passes in the breast milk, and there have been case reports of babies who have had seizures because of this exposure. In addition to cocaine, heavy use of alcohol and marijuana by breast-feeding women has been correlated with

There is a tremendous societal complicity in okay-drugs and not-okay drugs but the fetus does not know whether it is a legal or illegal drug that is cutting off its oxygen supply.

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delayed motor skills at one year. About four percent of the children under two who came through our emergency room in the inner-city of Boston because of runny noses and bumps and diarrhea, had cocaine in their urine and were probably passively exposed. Crack also has a morning-after syndrome typically associated with alcohol. With alcohol, parents would have a cocktail party and their toddler would get up, wander around and drain all the glasses, ending up in the emergency room drunk and hypoglycemic. Now with cocaine the baby may get up and eat bits of the drug that have been left around. Occasionally parents will intentionally administer drugs to their children to quiet them down. Whatever the postnatal exposure, it is probably more acutely toxic to babies than prenatal exposure because infants do not have the mother's metabolism to protect them.

Parenting: A Significant Risk Factor

Impaired parenting is also a major postnatal risk for these children. In one study, children whose mothers started using drugs after the child was born — they were not *in utero* exposed — were compared to children who were exposed to opiates *in utero* and the study found that both groups of children looked identical. A different study conducted in New Haven looked at all the babies in one hospital — both those who were cocaine-exposed and those non-exposed — and tracked them for 18 months. The study found that 23 percent of the cocaine-exposed and two percent of the non-exposed had been reported to their protective services. And what was statistically significant in this finding was that neglect was the reason for the reporting. Because when someone is profoundly addicted, as opposed to an experimental or occasional user, the need for drugs takes precedence over everything else. All the money and all the attention and all the energy goes away from the baby and into the drug. Alternative care for these children is often poorly supported and badly supervised. The number of children I have seen who have been maltreated in foster care is distressing, whether they were cocaine-exposed or not.

No researcher has yet done a controlled blind study for biologic cocaine effects which takes into account these children's home environments and the other many risk factors that are impacting on their lives. Are children prenatally exposed to cocaine any worse off than other children in America right now? To answer this question we return to the "horrendous" children in the classroom today, with problems that have not been seen before. Perhaps the answer to this phenomenon needs to be looked at holistically and not be restricted to the problems of cocaine.

All America's Children: In Danger, At-Risk

The children of America as a body are in trouble. In 1988, the National Center for Health Statistics found four percent of American children were developmentally delayed; seven percent had learning disabilities, and thirteen percent had emotional behavioral problems. Twenty-five percent of American children live in poverty. We wonder why we had not seen these children five years ago or ten years ago. Ten years ago we did not have 500,000 children who were homeless. And homelessness is totally preventable and totally related to disinvestment in low-cost housing.

The whole society makes money from the perpetuation of drug use. A leading beer company paid millions of dollars to have ET pop open a can of their beer and down a cold one and then a six-pack in the movie *ET*. In Sweden, alcohol advertising was banned and the consumption went down 20 percent. If you tax cigarettes, the rate of adolescent initiation — because teenagers cannot afford it — goes way down. But we will not do that. Selling crack on a street corner is a crime but selling cigarettes is free enterprise. There is a tremendous societal complicity in okay-drugs and not-okay drugs but the fetus does not know whether it is a legal or illegal drug that is cutting off its oxygen supply.

Deprivation

Besides the social risks that children are experiencing, there are enormous biological risks they suffer from deprivation. Five million children are hungry in the United States. Only one-third of the eligible children in this country get school breakfast — and any teacher will tell you how hard it is to teach a child who is hungry. Providing school breakfast is a social choice.

Malnutrition is preventable, lead exposure is preventable, recurring ear infections that can make children language-delayed and inattentive could be curbed with better access to medical care, and low birthweight is preventable with better access to prenatal care. We need to make sure that every child has a source of medical care. And this is difficult when there are 35 million children without health insurance. Children who cannot see, cannot hear, are hungry, or are sick cannot learn.

We are also seeing more children with grave problems in the classroom not because very low birthweight babies are being born at an increased rate, but in part because they are surviving much better. Our technology is keeping them alive, but there is about a fifty-fifty chance they will survive with impairment. And now AIDS, which is a horrible neurodestructive virus, is affecting chil-

dren whose parents have a history of substance abuse.

Locating the Problem

I would suggest to you that the major threat to our efficacy as educators is not what is going on in the minds of cocaine-exposed babies, but what is going on in the brain of our state legislators. Nobody can be an effective teacher with 30 primary children in a classroom, whatever the biologic burden of those children. Some people say, "But at least we can get the services for the drug kids." But these services are purchased at the price of stigma which may follow these children all their lives.

The specialized teaching measures that have been recommended for drug-exposed children is what all inner-city and at-risk children need and deserve. Highly structured classrooms, attention to emotional needs before cognitive needs, high student-to-teacher ratio, and supervision of and emotional backup for the teachers should all be "givens." These are services that a great many children in this country need, and it would be a shame if there was a child in a class who was setting fire to the teacher and you could not get help for him or her because he was lead-poisoned and not cocaine-exposed.

De-Mythologizing Crack Babies

I do think that prenatal exposure to cocaine is a problem, but the problem needs to be put into the context of our greater social ills and de-mythologized. Cocaine use in pregnancy is a marker for parents and children at very high risk. And like all families at medical and social risk, cocaine-exposed families require comprehensive intervention and care, including educational, medical and preventive services. It is my belief that for cocaine-exposed infants, as for survivors of most other neonatal stressors like opiate exposure, the quality of the postnatal care will be the critical determinate of outcome. Studies of "invulnerable children," children who have horrible histories and turn out fine, show that their "invulnerability" arose from an adult who cared about them individually and made them feel like they were worth something. By not recoiling from these children in horror, we can have an enormous impact on their outcome. I would like to end with the words of one of the great recovered cocaine addicts of all times, Sherlock Holmes, who said, "It is a capital mistake to theorize before one has data. Insensibly, one begins to twist facts to suit theories instead of theories to suit facts."

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Recognizing the Meaning of Motherhood for Women in Treatment and Recovery

(Commentary on ESC Video, Neither Damned Nor Doomed: Mothers' Perspectives on Children Exposed to Drugs & Alcohol)

Michele G. Shedlin, Ph.D.
President, Sociomedical Resource Associates

As a medical anthropologist, I work on a regular basis with substance-abusing women who are in recovery, about to enter recovery, or who are unable to get into treatment and the process of recovery. I am always impressed by the strength and eloquence of the women survivors of the drug world: I am impressed by their love, concern and need for their children; I am impressed by the role that the children play in their recovery process.

Substance abuse for many women is, first of all, an expression of distress. They are alone, they are young mothers, they are insecure, and they frequently have been abused. Secondly, drugs are part of their life situations. Many of these women have partners who are drug users and dealers. Drugs are all around and part of their environment.

And thirdly, substance abuse can be a very important coping mechanism for women who have little social, economic, emotional and psychological support. Cocaine especially can provide a feeling of empowerment, energy, self-assurance and self-esteem that they do not have without the drug. The meaning of and reasons for this are particularly important when we realize that the *new* use of drugs is twice as high for women as for men, and that in some places women users outnumber men for the first time.

Addiction is an equal-opportunity disease. Cocaine especially knows no social, economic or gender boundaries. Yet many of the issues that confront women differ dramatically from those faced by men. Women have a stronger tendency to depression. They have considerably lower self-esteem, which is both a factor in their becoming addicts and an impediment to their recovery. They have a perceived lack of empowerment and bear the crushing stigma of being *female* drug addicts. They are frequently dependent on men who are addicts themselves. They have eating disorders and weight loss. They have histories of physical, sexual and emotional abuse. They are involved in prostitution for their drugs. Pregnancy means single parenthood, which, with a lack of child care, may keep them out of the recovery process in

Addiction is an equal-opportunity disease. Cocaine especially knows no social, economic, or gender boundaries.

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a system that already has a lack of gender-appropriate treatment programs.

Not only do drugs affect children *in utero*, but they affect the quality of the parenting. Available income may go to purchase drugs. Extremes of drug-seeking behavior may cause mothers to neglect their children. Drug use means high rates of acute illness among these women as well as chronic poor health. In committing crimes to support their habit, they risk incarceration, which removes them from their children. Or, children are taken from them by the child welfare system because of their substance abuse. Chronic cocaine use, especially, manifests symptoms of depression, irritability, and anxiety which affect a woman's capacity to care for herself and her children. With drug use, women are more susceptible to stress and children are stressors, especially those impaired by maternal drug use. An impaired mother and an impaired child can result in a very volatile situation.

Children: Positive Factors in Mothers' Lives

But what do children mean in the lives of these mothers? Motherhood may be the only socially acceptable role available to them which will bring some self-esteem. And a child is something positive, someone to love them. A child is absolutely theirs. A child gives them a sense of purpose, of who they are, a sense of control, companionship. "Bottoming out" is frequently defined as when children are taken away. Yet, meet these women in recovery and you cannot fail to be impressed by their determination, sensitivity, tremendous perceptiveness, and insight. They are survivors, and they want their children to survive. They acknowledge their role in their children's problems because the process of recovery has allowed them to deal with their previous denial and they are no longer denying. They are reaching out to fight for themselves and to fight for their children and their needs. There is a dramatic difference between mothers who are still on drugs and who will not interact with schools, and mothers in recovery who are

The majority of programs that are available to women are based on a male model, and ***less than one percent*** *of federal funds directed at anti-drug programs are aimed at drug treatment for pregnant women.*

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reaching out for their children and themselves for answers and for reassurance.

What about treatment facilities and treatment programs that allow this healing and reaching out processes to take place? There are still few drug-treatment programs available and appropriate for women, especially programs that allow women to bring their children or that provide child care. The majority of programs that are available to women are based on a male model, and *less than one percent* of federal funds directed at anti-drug programs are aimed at drug treatment for pregnant women. Programs that recognize the needs of women in all their roles are needed — especially in their role as mothers, since children are obviously such a positive force and motivation for these women. We see that women find strength in their role as mothers, and they in turn positively affect the life and potential of their children.

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"So it's been me and my boy all the time. He'd follow me to the crack houses. I'd come out with vials and he'd be right across the street watching me like he was a bloodhound. Wherever I was he followed me."
Milca, mother

"Aside from the family structure changes, I'm seeing an extraordinary difference in the children's problems themselves. They seem to have many more difficulties with the kinds of skills they need to make it in school. Their small muscular coordination is terribly deficient; they have very severe language problems; their impulse control is very, very limited; they're active, they're moving all the time and they do not have the skills in June that I normally would have had with the same population in October.
Ina Weisberg, kindergarten teacher

Some Observations from the Front Lines

by Rachelle Tyler, M.D.
Department of Pediatrics, UCLA

As a developmental pediatrician, I have been following children prenatally exposed to drugs for about eight years. I usually begin to follow them at birth and, depending upon funding, I continue to observe them for as long as possible. The oldest such child I have seen is now eight years old. Unfortunately, studies or grants rarely provide enough money to follow subjects for more than three years. This means reapplying for additional money to continue to follow a cohort of children, and this money is often not made available. Because of this, few studies have followed children for an extended enough period of time to really observe long-term developmental problems.

Prenatal drug exposure has been around for a long time and it is found in all ethnic groups, all racial groups and all economic classes. As early as Biblical times, in Judges, we were told not to drink alcohol during the course of pregnancy because it may be detrimental to the developing fetus. It took us almost 2000 years to describe Fetal Alcohol Syndrome (FAS), and it was not until 1973 that FAS was officially described in this country. In the 1960s, studies on prenatal drug exposure focused on opiates because many opiate addicts were in methadone maintenance clinics and their children were easier to follow than those exposed to other drugs.

The research about these children concluded that any long-term developmental problems or learning disorders were probably a result of the children's chaotic environments and not biologically motivated. More recently, as studies of prenatal drug exposure have begun to look at PCP and cocaine in addition to methadone and heroin, we have been finding that even in a stable environment, children prenatally exposed to drugs may have learning problems later on.

But even as research on prenatal substance abuse has begun to branch out into new substances, it is virtually impossible to distinguish effects related to PCP from those related to alcohol or cocaine. Additionally, over 90 percent of women who use drugs are polysubstance abusers. Gateway drugs like alcohol and marijuana are often used in conjunction with illicit drugs like cocaine, PCP or

Unfortunately, studies or grants rarely provide enough money to follow subjects for more than three years.

heroin. Even if the mothers claim to be taking just one drug, because illicit drugs are not federally controlled, the pure substance may have been cut with another drug or even a household cleaning agent. A baby who is symptomatic of prenatal drug exposure will not have certain symptoms which show definitively what drug he or she was exposed to *in utero*.

In most cases, the effects of prenatal drug exposure are compounded by the postnatal environment these children find themselves in. Failure to thrive may be a problem in children with prenatal drug exposure. Children who fail to thrive lose weight, lose their height, and begin to lose brain or head size, which can interfere with learning or even cause retardation. Failure to thrive may occur because of irritability, difficult feeding, lethargy, and difficulty with arousal. A mother who is using drugs may be concerned with getting her drug habit met and may not be taking the time to feed or wake up an irritable or lethargic baby.

Problems of Testing for Prenatal Exposure

In California, not every mother and infant who presents for labor and delivery is tested for drug-exposure. In order to initiate a test, there usually needs to be some indicator of maternal drug use: a history of no prenatal care; if the mother's water breaks several days before she presents for delivery and she hides this, she may be trying to "clean out" drugs from her system; if the mother lives some distance away from where she delivered the baby she may be seeking anonymity to avoid recognition as a drug abuser; the mother may be withdrawing when she presents for labor and delivery; she may have four or five other children in foster care or in the care of relatives, and all of these are indicators which may merit evaluation of the family.

Drug testing most commonly involves doing a urine toxicology screen on the infant and mother because it is the least invasive and least expensive testing method. Blood tests are used if the mother or infant seems especially symptomatic of alcohol expo-

sure. The urine drug screen and blood test can only tell you what the baby or the mother was exposed to within the past 72 hours. If the mother took drugs during the entire course of the pregnancy and stopped three or four days before she delivered, then both she and her baby will probably test negative. This is frequently the case, especially if the mother stays out of the hospital after her water breaks and "cleans her system out."

Drug detection tests are also unreliable because of their lack of sensitivity. Because drug excretions in the urine are intermittent, a single urinalysis may not detect a substance; but because of the difficulty in obtaining specimens, it is usually not possible to administer a second or third test.

More recently, doctors have been testing the meconium — the first stool the baby passes which allows detection of substances to which the baby was exposed up to four to five months prior to delivery. This procedure, however, is still primarily used on a research basis.

A number of babies who have been prenatally exposed to drugs are lost to tracking in the newborn period. We have found, though, that they may reappear at five or six years of age with attention problems and poor peer interactions when they have not had the benefit of early intervention.

Symptoms of Exposure

The symptoms of prenatal drug exposure that are first identified in prenatally exposed infants are labelled as neonatal withdrawal symptoms. Despite the short-term implications of this classification, some of these symptoms can be indicators of a chronic problem. Babies who are irritable, who cry for extended periods of time, whose muscle tone is unusually "up" may actually have these same problems as children later on. We have seen infants who are difficult to calm down and unusually strong, and now teachers are saying these same children are still very strong. We have seen infants who have poor state transitions — they have a difficult time containing themselves and maintaining themselves in a quiet or calm state — and teachers are just now beginning to see these same problems in their students.

Symptoms vary from infant to infant and from child to child. All of the children who have been prenatally exposed to drugs will not necessarily have symptoms severe enough to affect them academically — and we should not look for something if it is not there. Symptoms will also vary according to the sensitivity of the examiner. When I look at children who are seven or eight years of age with problems in school, and I see their past medical history and I read that they had no symptoms in the newborn period, then I wonder about the sensitivity of their examiners. If the examiner did not know how to do a newborn neurological evaluation, did not know the symptoms to look for, then that child would not have been deemed symptomatic.

Complications: Premature Births, Low Weight Gain, Venereal Disease

Women who use drugs can have complications during their pregnancy or delivery which can affect their child. Four

It is vital that children at risk have developmental evaluations early on, opening up the possibility for early intervention.

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years ago, we looked at some women at UCLA who were using drugs in the prenatal period and we found that 30 percent of these women delivered their children prematurely and a premature baby is, by definition, a high-risk baby. Drug-abusing mothers have a higher rate of spontaneous abortion or miscarriage. They have poor weight gain, and many times this means poor weight gain for their children. The mothers will have alterations of their blood pressure — high blood pressure or low blood pressure — and when the mother's blood pressure is altered the baby's blood pressure is altered as well. This means the baby will suffer from episodes of hypoxia or diminished oxygen, which can affect the brain.

If you have a mother with limited financial resources, isolated, with most of her family on drugs, she may have to prostitute to support her habit. When the babies get venereal diseases, this can mean long-term complications. Congenital syphilis, herpetic encephalitis and CMV can all cause mental retardation, seizures, hearing impairments, learning disabilities or cerebral palsy. If the mother is using cocaine the high only lasts 15 or 20 minutes, and she may have to get high anywhere from 15 to 30 times a day. Fifteen to 30 times a day means a lot of exposure for her and a lot of exposure for her developing fetus.

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) is the full expression of the effects of prenatal alcohol exposure. Three characteristics are traditionally associated with FAS. The child is usually born small and will remain small in head circumference and height. The child actually may be of normal weight or even obese in later life. The child with FAS may have some sort of central nervous system abnormality — mental retardation at worst or it may just be an attention deficit. The FAS child can also have dysmorphic facial features. This can mean mid-face hypoplasia, or a small middle face region; their eyes are small if you measure from corner to corner; epicanthal folds or the extra fold of skin like the children in Down Syndrome have; a flat, upturned nose; an indistinct philtrum, a flattened or broadened nasal bridge; a thin upper lip; strabismus, or

crossing of the eyes; ptosis where the eyelid is dropped; or they may have malformations of the external ear.

Discovering FAS Effects: A Model for Diagnosing Prenatal Cocaine Exposure

Fetal Alcohol Syndrome is the physical manifestation of a process that has taken place within the fetus prenatally exposed to alcohol. Fetal Alcohol Effects (FAE) is slightly different because although the developmental problems may be the same, the child with FAE will not necessarily show the identifiable physical manifestations that help to articulate the problem. The lack of physical signposts in FAE is perhaps a model from which to understand that complicated procedure of identification in most drug-exposed children. And although they may not exhibit external features to orient us to their problems, drug-exposed children can have developmental problems which will exhibit in the arena of their learning and behavioral skills.

Because of the varying degrees of susceptibility to prenatal drug exposure among children, and because developmental problems are not always easy to assess by caretakers, it is vital that children at risk have developmental evaluations early on, opening up the possibility for early intervention. Caretakers may only have a child two years of age, and they expect two-year-old behavior from that child, but the child may only be able to perform as a nine-month-old. And you may have children in school who are seven or eight years of age who are behaving like three- or four-year-olds. This can be frustrating for any caregiver or teacher who is not ready to work with them on developmentally appropriate levels. By having a child evaluated formally, an objective observer can assess what to expect from this child and what is appropriate with respect to interacting with this child.

Various Evaluations

Some developmental evaluations that we use are the Brazelton for the newborn period or Bayley's Scales of Infant Development. The Gesell is still another assessment tool. The Denver Developmental Screening Test is used by many nurses. More recently, observation of play is being used as an assessment tool. The child is placed in a room for 20 or 30 minutes and left to play spontaneously. This is a good indicator of whether or not children have difficulty organizing themselves. A very structured activity, presented to them one-on-one, may demand constant modeling. Children do improve over a period of time if activities are constantly modeled, but this again suggests the real need for early intervention.

Tests for developmental outcome also explore gross motor skills, fine motor skills, adaptability, language skills, and personal and social skills. These areas are all part of structured evaluation. Children at six months of age may be starting to exhibit fine motor difficulty which may continue for a long period of time. At six months this may mean minimal vocalizations, and when you see them in school, their language may be delayed or their speech indistinct. We are discovering that these disabilities may be identified early on with the assessment of fine motor skills. Children with fine motor difficulty may have a difficult time feeding as

All of our findings about this population of children ran along a spectrum of experiences. Some of the children are maximally involved, and others are minimally involved.

infants — if your small muscles are not working, you can not use your mouth and your tongue very well. This makes it difficult to speak.

A Pilot Program in Los Angeles

As our developmental assessments took children into the preschool range, a pilot program was begun in Los Angeles specifically for children who had been prenatally exposed to drugs. The program was not created in order to assert that these children necessarily should be separated from children who did not have prenatal drug exposure. We started the program because we wanted to look at these children and see what the particular problems are in this population and what intervention strategies can best serve them. The program is now four years old, and one of our main goals is to mainstream the children into kindergarten and the first grade. After these children complete our program and enter kindergarten in their local schools, there is no record that they have been in a special classroom.

Some Observations

All of our findings about this population of children ran along a spectrum of experiences. Some of the children are maximally involved, and others are minimally involved. Some of the children have gone into gifted reading classes in the first grade, whereas others may have learning problems. They may have visual processing problems. They may judge each stair to be, say, maybe six inches tall when the stair is actually nine inches tall. Then they will trip, not because they have problems with their motor skills but because they are having problems processing their visual information. If children have problems with attention — they move in one direction and look in another — then of course they bump into something. Clumsiness may in fact be related to their attention deficit or their visual processing problems.

Speech Problems

We found that some of the children have intermittently indistinct speech. One day their speech will be very distinct and, the next day, it may be quite difficult to understand. Teachers have found that

this is sometimes related to the child's experiences at home, over the weekend. A mother may be trying to get off of drugs and she may not have had her child for the first three or four years of life and the child has been in a foster home setting. The child may begin making weekend visits back to the mother and that can be disorganizing to the point that the child begins to speak indistinctly and regresses. Although this scenario is seen more frequently in a child who is at-risk developmentally, this happens to all children. There is regression when there are changes in the regular routine.

Difficulty With Social Cues

Children who may have been very lethargic, unresponsive, or extremely irritable within a few moments of quiet alertness, during their first years of life will have a harder time picking up social cues because they were not able to observe them at a young age. For example, a child throws something at me — I make a grimace. The child does not respond to this expression in a way that shows he or she understands that the action was unacceptable. As the child gets older, his parents may not be teaching him these social cues — they may talk at him not with him. Teaching interactive signals through constant modeling is extremely important. Eye contact should always be made, and it is often helpful to use physical cues by touching the children gently to redirect them.

Transitions

Many of these preschoolers have difficulty with transitions. A child may have a problem starting a play activity. Then when you want to stop a play activity and move on to something else, he may have a difficult time coming out of that activity and moving to another. To compensate, transitions should always be prepared. The child should be told in advance about changes in the schedule, and the reason for change should be explained. The child should be able to ask questions about the schedule so he can become involved in decisions that concern him.

Limited Problem-Solving Abilities

These children may have limited strategies for problem solving. A child who is trying to solve a puzzle may be convinced that a particular circle must absolutely go into a particular square and not look for any other way to solve the problem. Experimenting with other choices has to be modeled for the child many times.

Sporadic Mastery

Sporadic mastery of tasks is another characteristic we found. The child may know how to do a task one day and, the next day, he or she may not. This is very frustrating for the children because many times they know that they performed the task previously, but they are unable to do it again. This affects the children's self-esteem, if they see their other classmates doing these things, and they know that they were once able to do the task themselves. This is very difficult for the child to understand.

One Case Study

This case study of an eighteen-month-old boy is characteristic of many of the children who have had prenatal drug exposure. His mother was about 18 years of age when she delivered him. She was

Effective planning involves an interdisciplinary approach. Teachers can not do everything for these children. Psychologists, social workers, public health nurses and community resource people all need to work with the children in concert to best serve them.

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using PCP and cocaine. At two days of age when I first saw him, he was very disorganized. He was in constant motion and I had to wrap him up to try to get him to interact with me, but he would not respond. He had spontaneous smiles every two to three minutes which told me that his nervous system was not organized because children do not engage in social smiling until they are six weeks of age. He was discharged home to a maternal relative, whom we later found out was also using PCP and cocaine. So he was removed from that home. Like this boy, many of these children have had prenatal drug exposure and then drug exposure in the postnatal period as well, if their parents are still using drugs. If they come to school one day very disoriented, there is a strong possibility that the mother or father may have been smoking PCP or cocaine at home. Until 18 months of age, he was placed in a foster home, and when I saw him for developmental evaluation, he was in need of containment. When I sat him down to play, he clawed me and his caretaker. When I held him, he was content; but he was unwilling to play by himself or sit alone in the crib.

I lost track of the boy until he resurfaced at three years of age, when he entered our preschool program. By that time he was back with his mother who had completed drug treatment and who had been to parenting classes. She had since delivered a subsequent child with no prenatal drug exposure.

The first boy was progressing nicely, but he was still having difficulty containing himself. He would go in the yard and see other children in the swing and want to play on the swing himself. But when he was in the air, he would get a look of terror and would have to be brought down and held. During the course of the two years that this boy was in our program, his teacher tried to help him to become aware of when he was having problems and learn to ask for help. Some of these children have tantrums and act out without realizing they are out of control and without knowing how to get help. Many times in their home environment they are not encouraged to seek

help because they have parents who basically need parents themselves.

Some Advice

With school activities it is important to remember your limitations. The children's daily activities should be predictable. Many of these children come from unpredictable home environments with no clear pattern to their daily experience. The school day should counterbalance this chaos with a sense of order and identifiable patterns so that the child can understand and feel some control over his or her destiny.

Consistent Praise

These children must be consistently praised for their accomplishments because they may not get this reinforcement at home. They may do whatever they want without their parents asserting whether their behavior is acceptable or not. Without this kind of feedback they cannot learn to distinguish whether or not their behavior is appropriate.

Environmental Regulation

Environmental regulation is an important element to creating an effective classroom experience. Understandably, this can be difficult to enforce in a school setting. These children need a quiet situation with few outside intrusions. The teacher and aide should be a consistent and dependable presence in the class. Substitutes and location changes should be minimized. These children's home lives may involve different caretakers coming in and out, parents who leave them for extended periods of time and constant movement from one location to another. There should also be minimal exposure to visual and auditory stimulation. Often premature babies need external stimulation, but this population of at-risk children may be different. Too many objects around the room can be distracting and confusing for these children.

Constant Repetition of Task

When some children are presented with a task, they can spontaneously figure out what to do, and that is also true of some children who have had prenatal drug exposure. But some will have to be talked through a procedure over and over again. These are the children who have problems with their short-term memory. Because of varying degrees of damage to the central nervous system, it is difficult to tell how much damage there has been from one child to the next. In the case of short-term memory, constant repetition of tasks is necessary. These procedures should be verbalized by the children because this helps them to internalize information and retain it on a more long-term basis.

Allow for Expression

All children should be allowed to express themselves. Sometimes it is very difficult in the school day to deal with expressiveness when you are trying to teach basic materials, but many times these children do not have that opportunity in the home setting and in their community setting to express what they are feeling. These children have a lot of concerns and fears, they have chaotic home situations, and they have a lot of feelings related to their situations. Additionally, try to offer some strategies to help the child to deal with their anxieties. Often the relative or caretaker of the child can be a valuable resource to work with or the community

may have a helpful program to work through.

Teamwork is Critical

Effective planning involves an interdisciplinary approach. Teachers cannot do everything for these children. Psychologists, social workers, public health nurses and community resource people all need to work with the children in concert to best serve them.

It can be very frustrating to attempt to make everything better in one year. Family issues that are affecting a child may have been going on for generations and just a year or two of schooling or intervention will not necessarily do the trick. There must be a long-term focus in terms of helping children and their families.

Small classroom settings are ideal — no more than 15 children, one teacher and one aide. But usually that is not the case. With unlimited class sizes in some Los Angeles communities, mothers or maternal grandmothers have gone into the classroom to act as teacher's aides. They are approved by the school district, and they are volunteers. They may have a child who is eight or nine years of age. The child did not necessarily have prenatal drug exposure. They live in a poor community, or they may have a number of children in the classroom who did have prenatal drug exposure, who are acting up. They volunteer to help the teacher in the classroom, so that their children can learn and the other children can learn. Incentives like that can be valuable.

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A Framework for Evaluating Children Prenatally Exposed to Crack

Steven Merahn, M.D.
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As a pediatric consultant to the Bureau of Day Care for the New York City Department of Health, I worked as a physician in a bureau with 25 graduate-trained early childhood educators. Collaborating with developmental psychologists, educational administrators, early childhood education specialists and infant care specialists, I learned that as a physician, the conceptual base I used to understand and assess children was different from that of my co-workers. As a pediatrician, I use a biological framework to assess children's behavioral, cognitive and emotional function — a framework that is particularly helpful in understanding the developmental issues for children prenatally exposed to cocaine.

Cocaine: Often Only One of Many Risk Factors

In utero exposure to cocaine is a biological experience that must be assessed with regard to the dynamic quality of the fetus and the multitude of experiences that impact upon it. The constitutions of both the mother and fetus will help determine the effect of the cocaine — some systems are biologically unprepared for cocaine because they are missing certain protective enzymes necessary to metabolize the drugs. Other systems have a more active metabolism which serves as added protection against cocaine. In addition, most substance-abusing women are multiple drug-users, and it is difficult to distinguish the effects of one substance from another. Substance-abusing women are often biologically at risk for any number of disorganizing experiences to the fetus. Not only can it can be difficult to identify the exact cause of these many disorganizing fetal experiences, but even less is certain about what long-term developmental meaning they may have.

A New Syndrome In Our Classrooms

Despite the inadequate assessment tools we have for pinpointing the exact biologic cause of developmental dysfunction, we are seeing a new syndrome in our classrooms. Although the syndrome has multiple factors, prenatal exposure to cocaine can be a starting point for beginning to understand these children's learning problems. It is known that cocaine is

a powerful neurotransmitter and, taken during pregnancy, it may effect the sensitive neurologic tissue of the fetus. In particular, it is hypothesized that this neurologic damage may be occurring in the mid-brain, about which researchers still know very little.

The mid-brain is responsible for motivation, affect, drive and figure-to-ground relationships. Figure-to-ground relationships involves the ability to discern foreground and background in a visual image, or on a neuropsychological level, being able to discern what elements to pay attention to in a conversation and what to ignore. Perceptual elements in mid-brain functioning also involve social-cueing and appropriate action-taking. If a child walks up to a group of children playing with blocks, does he or she know how to enter that group? What is his or her perception of the group dynamic? Are these the developmental skills that children prenatally exposed to drugs seem to be dysfunctional in, as opposed to the more cognitive skills of thinking — problem solving and language — which are based in the cortex of the brain?

Postnatal Problems

Whatever biologic experiences a fetus experiences *in utero,* they are often compounded by the child's postnatal environment. Mid-brain deficits can as easily be explained by examining the disorganizing experiences a child may experience in a substance-abusing household. A child who sees her mother sitting, crack pipe in hand with sweat dripping down her face, and is told to get out of the room will feel rejected without understanding why. She will receive conflicting behavioral clues and have no model for interpreting her experience. If a child lives in an environment where violent emotions serve as the basis for many interactions, the intense negative energy of these experiences will affect and shape that child's response. And this will carry over into all their future social interactions because, much like the developing fetus, children cannot always discern whether their experience is normal or not, and they respond to what they get.

A Telling Story

I received a call from a prominent Upper East Side elementary school in Manhattan about a year and a half ago that was having problems with some of the first grade boys. The school had an ethnocultural mix, and they were having trouble with some children from the less-affluent neighborhoods during playground time. These boys had exhibited a lot of very hyperviolent, hypersexual acting out on the playground, and they asked me to come and watch.

What I saw was six- and seven-year-old boys who were imposing graphic sexual imagery on the little girls around them. The teachers panicked and thought the boys must have been sexually abused in order to have knowledge of this level of sexuality. They asked the parents to come in for a conference, which I attended as an observer. My observation was that these parents were struggling lower middle class families who lived in their neighborhoods because it was the only place they could afford an apartment.

I went to their neighborhood, and I found a group of men hanging out at 154th Street. Every woman that went past them

Mothers who have children prenatally-exposed to drugs and are trying to help their children, realize that the family environment and the interactive environment are far more important than the fact their children had a biological experience that put them at risk.

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was verbally accosted. This was the same street where these boys played every day, and being six- and seven-year-olds, they were at a developmental stage where gender boundary issues become relevant. So they pulled role models from their environment to meet what were developmentally appropriate drives. They had no outside reference point to assert that this language was inappropriate because the male role models in their community were that reference point.

When these children enter the classrooms, we are seeing them in the context of their postnatal environment, and that is where we need to look for intervention strategies that will be successful. This intervention needs to begin by looking at interaction pathology. Mothers who have children prenatally exposed to drugs and are trying to help their children, realize that the family environment and the interactive environment are far more important than the fact their children had a biological experience that put them at risk.

Child Assessment and Intervention

The first place to make an assessment is with the child. Does this child have any biological experiences that puts him/her at risk for interaction pathology? We know that babies at risk only due to low birthweight have an interaction pathology. They do not feed like full-term babies, they sleep more and they have problems controlling their actions. We also know that by structuring their environment they can rapidly be brought to an appropriate developmental level. Infants who spend time in intensive care nurseries are at risk for interaction pathology. Infants with congenital anomalies themselves are at risk for interaction pathology. Infants who may have a documented drug exposure are at risk for interaction pathology. When we have a child with a known risk factor due to a known biological experiences, this is reason for intervention.

Parent Intervention

The second area for assessment is with the parent or the caregiver. If the parent is still using drugs we know that they

It should not be the job of the school and the family alone to help a child succeed. It is the responsibility of the community as well to be responsible to their children.

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themselves have an interaction pathology. Drug use can lead to short-term neurological impairment. This leads to perceptual differences in terms of interaction. Parents may also have underlying mental illness. They may have a character disorder. They may have depression. As many of us do, they may simply be experiencing stress.

Community Intervention

The third area in which we need to make an intervention for interaction pathology is at the level of the community. This means fostering a sense of mutual responsibility between each person and his or her community. When a man or woman chooses to wear a provocative t-shirt, where is this sense of responsibility? Adults must realize that almost every child from age six can read what it says. It should not be the job of the school and the family alone to help a child succeed. It is the responsibility of the community as well to be responsible to its children.

Above and beyond the issues of isolation and lack of resources, which are the traditional problems when we examine the community, we need to look at the nature of interaction not just in the context of the family itself but at the boundary between the family and community and how that will affect children at various points developmentally. By looking at a child's development within the framework of ongoing biological experiences that begin with conception, it is possible to better understand all the many variables that impact on their ability to learn and function to their full capacity.

The Biologic Framework

There are three basic categories of biologic experience that inform a child's prenatal and postnatal development. These categories are exposure to 1) biologic matter, 2) energy, and 3) information. Biologic matter includes materials like iron, calcium and oxygen which are critical to the proper growth of a fetus. A fetus whose mother is malnourished may not get enough of these critical bits of matter and a fetus whose mother is abusing drugs may be exposed to other matter that is harmful to its growth. The developing fetus has no ability to discern whether the quantity and types of matter it receives

A wide variety of variables from interaction with the caregivers and community to lack of resources and isolation as well as the timing and nature of biological experiences, impact the prenatal and postnatal development of every child before he or she enters the schoolhouse door.

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are normal or not, so it will react to whatever it is given. If the fetus does not get enough of a certain material, it uses what it can; if it gets too much of a certain material, it will try to accommodate the excess in its system. Disproportionate amounts of biologic matter can affect the way the fetal system is organized and develops over time.

The primary biologic source of energy for the fetus is glucose which is derived from sugars, fats, and carbohydrates. A fetus that is cut off from sources of energy or overwhelmed with energy will have a disorganizing experience. Neurotransmitters are one carrier of biologic information within the fetus. Cocaine blocks the uptake of these neurotransmitters which can alter the initially intended informational experience of the fetus.

The Mother and Her Unborn Child: A Shared Biologic Experience

These three areas of biological experience for the fetal system take place within the context of another biological system. The primary root for the relationship between the fetus and the mother is the mother's bloodstream. It is through this bloodstream that the fetus accesses the material, energy and information that is so crucial to its development. If there is a problem with the mother's biologic machinery or if she allows harmful substances to enter into her bloodstream, this may complicate or disorganize the biological experience of the fetus. If the mother has untreated high blood pressure, the blood flow to the fetus will be diminished; diminished blood flow will in turn limit fetal access to biologic materials necessary for proper growth and the result will be a low birthweight baby.

Prenatal Development within a Dynamic Fetal System

Prenatal biologic experiences takes place within a dynamic fetal system. Once conception takes place between the sperm and the egg, a biological machine is put into place that operates without pause throughout the nine months of gestation. Pregnancy is traditionally divided into three trimesters and, over the course of each trimester, a different stage of fetal development occurs. In the first trimester, the feial cells proliferate and differentiate

— cells begin to organize themselves into a kidney, the heart, the central nervous system. In the second trimester, these organ systems develop into functioning units and, in the third trimester, the size of these units are determined. Developmental outcome depends on what trimester of growth the fetus is undergoing when a disorganizing biological experience occurs. If a mother is infected with the acute illness rubella during her first trimester of pregnancy, the child may contract congenital heart disease because the fetal system will be effected at the point that it is organizing its cells into a heart. When the rubella virus invades the fetal system, it has a particular affinity for immature heart cells. These infected heart cells become swollen and the cells developing beneath them alter their course to avoid the swollen area. The fetal system does not know to halt the growth process and wait for its defenses to remove the infection, so instead the heart grows off to the side. But if the mother only contracts rubella in her third trimester, the child will probably not be effected because the formation of the heart will already have taken place within the fetus.

Looking Beyond Biology to Understand Child Development

It is clear then, that development of the fetus is affected not just by its biological experiences, but also by the *timing* of those experiences. It is equally clear that a wide variety of variables, from interaction with the caregivers and community to lack of resources and isolation as well as the timing and nature of biological experiences, impacts the prenatal and postnatal development of every child before he or she enters the schoolhouse door.

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Project Daisy: A Regular Education Project for Children Prenatally Exposed to Drugs and Alcohol

Diane Powell, Ph.D.
Project Director, Project Daisy, District of Columbia Public Schools

Project Daisy is a Washington, D.C.-based regular education project that seeks to discover how best to educate young children who have been prenatally exposed to drugs. When we talk about these children we are not dealing with a biologic underclass, we are not dealing with children of the damned or children of the doomed. *We are dealing with children.* Children who have been prenatally exposed to drugs are coming into classrooms. They will be there just like other children. Many children have risk factors. Project Daisy's primary goal is to educate young children by being aware of the problems that they may be confronting as they enter the classroom each day and by finding ways to compensate for these problems.

A Regular Education Project

Our project is different from some of the other programs for children prenatally exposed to drugs because we are not a special education project. Project Daisy is a regular education project based on the full inclusion and total integration of children who may have risk factors. Initially envisioned as special education, it became clear that children have the right to be educated in an appropriate environment that can support them before they are placed in an alternative setting. It is more expensive for us not to classify the project as special education because, by identifying them as "special-needs children," federal money becomes available. But we felt strongly that Project Daisy had to be envisioned as a universal approach to educating young children, not as a special unit for special-needs children.

As a regular education project, our classrooms do not exceed 15 students, each with a classroom teacher and an aide. Our classrooms are designed to be multi-age-level so that children can enter at age three and exit at age five. This way children can be in a stable environment for several years, which gives them an opportunity to bond with a teacher and aide in a consistent way. Our classrooms are supported by a multidisciplinary team that is comprised of a clinical social worker, a clinical psychologist, and a speech-language pathologist. This unit of professionals is then supplemented by collaborative support from other agencies.

Interagency Cooperation: Owned by All of Us

The notion of interagency cooperation was crucial to the design and creation of Project Daisy. Our staff comes not only from the public schools in the District, but from other agencies as well, so that we all have a part in the solution. Together we developed a shared vision, a shared mission and a shared ownership of all the issues and various types of problems that these children would be facing. We agreed to share our fiscal resources and because of this, ownership for the project is not claimed by any one agency or any one school system because it is owned by all of us.

Setting Up

When we began to look at how to set up our classrooms, we decided to put one into each of the District of Columbia's four quadrants. Within each quadrant we chose an area with a high probability of finding other children besides those prenatally exposed who would have risk factors. Our classrooms were then placed within the pre-existing early childhood unit of the schools we ultimately chose.

Often what can happen in specially designed education programs is that children are segregated from the beginning, so they become "those children." But our children are a part of the total school building; they are a part of the early childhood unit, and they have regular education teachers.

These teachers are supported by strategies taken from special education and from the best practices in early childhood education. And when we say that we stress teaching that is developmentally appropriate for young children, it is clear that our practices should simply be those used with all children. That is exactly what we advocate through our regular education status. There are times when we have to use what we consider to be reasonable accommodations, and we have done some things that are extremely different in terms of the environment. But our goal is that ultimately the strategy of using "the best practices" should be the norm in every regular education classroom.

Our classrooms are large and accessible with specialized areas so that the children can move easily from space to space according to their needs. We tried to make each of our classrooms child-centered so the children would feel in control of their environment and totally at ease within it. Some of the children need a place to go that feels safe and so we built lofts in the classroom and designed child-sized carols to give them areas to play in with no stimulation. At the same time, we kept in mind that eventually most of these children would need to be able to learn in a regular classroom because that is the future for which we are preparing them. And so we also have environments with things that you would find in any other preschool classroom.

The Importance of Adult-Child Interaction

Thinking about our goals, we recognized that young children need to have an opportunity to bond with a significant adult, and that is particularly true with these children, where many come from foster families, some are "boarder babies," and others are being taken care of by grandmothers who have already raised

We needed to provide a consistency in the school because many of the children in our program were not getting it at home.

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their families. We found that while many of the children were well taken care of and came in clean and neat and certainly happy, an element of nurturing was missing. In most instances, this does not mean that people do not care about the child, but the reality is these children's caregivers were tired — they had already raised six or seven of their own children, and some of those children were still living in the family and suddenly they had a three-year-old or a four-year-old or five-year-old living with them who may be causing problems. The child may have behavior problems, may not have normal sleep patterns, may have trouble socializing. We had some parents or grandparents who were feeling somewhat helpless.

Consistency is Key

We needed to provide a consistency in the school because many of the children in our program were not getting it at home. To do this, we looked at how to formulate relationships from teacher to child, from child to teacher, from child to child, and from the child to the group. One of the things that we found by having non-exposed children in the classroom is that we were able to give children some very important pro-social models in terms of play behaviors, interactive behaviors, and language behaviors that we wanted these children to begin to present. We also looked at learning as an interactive process: in class we introduce concepts in a way that allows the child to become involved in his or her own learning instead of presenting information in a way that only involves the child's listening.

Issues in Maturation

Because some of our children are with us for three years, we also deal with the issue of maturation. Even over the course of a single school year something occurs. Learning occurs. It is dynamic. It is not stagnant. So children who might have come into the classrooms and presented with behaviors that were extremely atypical: excessive tantrums, heightened aggression, inability to take naps, were not doing that in June. We document these behavioral shifts through the maintenance of anecdotal records because these developmental shifts are especially relevant with at-risk children.

By having non-exposed children in the classroom, we were able to give children some very important pro-social models in terms of play behaviors, interactive behaviors and language behaviors, that we wanted these children to begin to present.

We found that the drug-exposed children do not present significantly differently from their non-exposed, at-risk peers. When we had our researchers document behaviors, it was clear that all children have certain types of behaviors at particular stages of their development. We saw that all of the children who had never had school experiences were more involved in motor activities. They moved around the classroom. They explored the environment. We looked at the degree, the intensity and the frequency of their movement.

We also saw that many of our children were aggressive. But again, many of our children live in environments in which there is a lot of aggression. They may see a mother getting abused; they may have seen someone getting shot in the neighborhood; they may watch a lot of television. Because children model their behavior based on what they see, this aggressiveness is often reflected in their classroom play.

We had children who came in and did not know how to handle toys. A little girl and a little boy were playing in the doll corner with a doctor's kit and instead of taking the stethoscope and putting it in his ears and testing the girl's chest, the boy used the stethoscope as a kind of cord that he wrapped around his arm. He took a pencil and pretended that he was shooting up and said, "Look, this is how you do it."

Intensive Teacher Interaction

We look at our children, assess where they are and begin to model alternative behaviors with them. We ask children why they think their choices are good ones. A lot of the behavior modeling that teachers normally do is simply done more intensively in our classrooms. We look at the fact that the children have an excessive need for being held and nurtured by teachers, and not all teachers can do this. Some teachers work with young children, but they do not want children to be on their lap a lot. Because these contacts needed to be available in our classrooms, we looked for teachers who were willing to offer this kind of nurturance. We also wanted teachers with personalities that are accepting of differences and teachers who understand that children

Educators who have seen the type of media that we have all been exposed to about children prenatally exposed to drugs are scared about receiving these children in classrooms that are already crowded.

who come from culturally different environments will reflect that environment in their behavior.

Family Interactions: Taking the School to the Community

Family interactions are also an important element in our program. A large component of our program is home-based intervention. We take into the home strategies that are working effectively with the children in the classrooms. Many of our parents are not available to come into the school and for some this is because school has not been pleasant for them and so they keep their distance. Instead of expecting their presence, we take the school to them — to their community.

We believe very strongly in bringing the resources where they need to be. The speech-language pathologist may go out to the home and work with the parent and say, "Look, when you're washing dishes, these are some things that you can do with your child that will stimulate language," and give examples. We realize that a lot of our parents are limited in terms of the finances that they have. And for them to buy a lot of different types of equipment would be a hardship. So we go into their environment and help them learn to work with what they have. We are trying not to operate in a deficit model, instead we look at the strengths both within the children and their families.

Because our program is short-term for these children, we designed a transition support model to help a child's movement from our environment into the receiving school's first grade. We talk with the principal about the child, the environment he or she will need, the type of teacher and the supports that the child will need. We explain some of the strategies that we have used with the child that have been successful. When we do this, the principal, the teachers and the school are more receptive to working with children who may need additional support and reasonable accommodations.

Fear of "These Children"

Educators who have seen the type of media that we have all been exposed to about children prenatally exposed to drugs are scared about receiving these children

in classrooms that are already crowded. This is a legitimate fear because no child can be well educated or even well contained in a classroom with over 27 children. In the District of Columbia, we are trying to lower the ratio of students to adults in all of our early childhood centers with a long term goal of only 15 children, a teacher and an aid in each classroom. Again, we are trying to stress the universal applicability of Project Daisy's approach to regular education.

Behavioral, Not Cognitive, Problems

We know that it is not practical to think that the solution to these children's problems rests solely in special education. Nevertheless, we know that many children who have been prenatally exposed may present neuro-behavioral defects or have gross physical anomalies which necessitate support beyond what we can provide within the confines of a regular classroom.

But one of the things that we have seen is that the majority of these children are cognitively intact. When we test these children with dial screenings and audiological screenings, when we get developmental information from pediatricians, and when we study cognitive performance in the classroom, we have found that these children are able to learn like their peers.

What is problematic is their behavior. We are finding children who have overly aggressive thematic play; we are finding children who do not stop, they move all the time; we are finding children who are very destructive in the way that they handle materials; we are finding children for whom the environment itself may be overstimulating.

Project Daisy is trying to find ways to compensate for the behavioral problems without stifling the child's opportunity to learn at a pace appropriate to his or her cognitive skills. And that should be the goal of every regular education classroom for every child that comes to school to learn each day.

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Project Healthy Choices: Building Stronger Voices

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Project Healthy Choices, Bank Street College of Education

Initiated three years ago at the request of the New York City Public Schools, Project Healthy Choices is a comprehensive prevention and education program for young children, their caregivers and families. We emphasize an integrated approach to prevention education, including the children, the families and the caregivers, in order to break down the we-them barriers. An integrated approach helps us define challenges in a comprehensive manner. It also helps us to work together to generate solutions and to reverse the sense of fragmentation and powerlessness we often experience.

In school districts across the city we have worked with prevention programs already in place supported by the public schools. These programs educate and train kindergarten, first and second grade teachers to recognize the impact of substance abuse on their students and to develop curriculum materials appropriate to their age group that children can use to help them make sense of their experiences. We work with parents to help them identify their role in prevention and we work with the community to develop resources for its families.

Project Healthy Choices believes that if we fail to recognize that children from the world of crack, whether prenatally or environmentally exposed, are at risk of repeating the same patterns of substance abuse as their parents, then we have done these children a great disservice. In fact, this observation can be taken one step further. If we fail to recognize the need for alcohol and other prevention education for all children and their families, then we will have done a disservice to all children. We live in a society where substance abuse in all forms impacts the lives of all children and this is a central premise of Project Healthy Choices.

Working With Teachers and Parents: Earliest Memories are Important

We begin our work with teachers and parents by asking them to go back to their earliest memories of substance abuse and use in their lives, whether it was in their family or their neighborhood, whether it was positive or negative, to remember what it felt like, what happened, what it was like to experience as a very young child. We begin with *self assessment.*

If we fail to recognize that children from the world of crack, whether prenatally or environmentally exposed, are at risk of repeating the same patterns of substance abuse as their parents, then we have done these children a great disservice.

And as we explore this very complex topic, we go through the many layers of substance use and abuse experiences that people have had. The idea is to heighten the awareness of adults of what it is like for very young children, how they learn, how they learn through their experience, their five senses, their curiosity, and from the immediate world around them.

Their Problem, Our Problem

The special education program of Project Healthy Choices is geared towards young special-needs children. The project grant states, "with special emphasis on children exposed prenatally to crack cocaine." While this is the subset of at-risk children we are focusing on in this program, we try very hard not to send the message that other drugs, legal and illegal, are less important or not as worthy of our attention or have less impact on children. In launching the pilot program in three New York City school districts, we were basically taking the Healthy Choices concepts and exploring how special-needs children as well as their teachers and parents would respond to the idea of designing a curriculum specifically for them. We would assume nothing without direct input from and field testing with actual children, teachers and parents. As a substance-abuse prevention education program for young children, we realize our curriculum speaks to a certain number of the children around the very issue which is one of the defining features of who they are — children prenatally exposed to crack.

We felt we needed to increase the sensitization and attitude exploration that we do with teachers and parents in order to prevent yet further stigmatization of children who are already labeled and categorized in damaging ways. It is confusing enough for young children to handle all the complexities of substance abuse that impact on their lives, but to have it define them seems a cruel and unjust burden.

All Children Need to Make Healthy Choices

The first challenge of our program is to recognize that all children need substance-abuse prevention education. We

All young children have been exposed in one way or another to drugs and alcohol if they live in this society.

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know that children with special needs require special support services across the board, and these are many and varied. However, the weakening of the public will to provide these services adequately is a social tragedy, and this must change in the future. The denial of society about the impact of the broad spectrum of alcohol and drugs on young children is another social tragedy that we must address.

A Continuum of Drug Exposure

All young children have been exposed in one way or another to drugs and alcohol if they live in this society. At Project Healthy Choices we think about it as a continuum — starting with exposure *in utero*, to family use, to neighborhood and community use, to peer use at school, and finally to exposure in the media and in society at large. If anyone cares to talk with and listen to young children about what they know and feel about drugs and alcohol, they are in for a disarming surprise — children know plenty, they feel plenty, and they ask a lot of questions when they are not simply asked to parrot back "just say no."

Healthy Choices now has a large collection of drawings and dictations and lists of questions and quotes from very young children on how substance abuse affects them. It is a most extraordinary needs assessment.

When we go into the schools to run teacher education workshops or to work in the classroom with teachers, assistants and children, we find the adults asking: *"How do we work with these children, at all?"* This question reflects the doomsday prophecies of the mainstream media for the children from the world of crack.

But when we ask teachers to explore the notion of what strategies they have always used to work with distraught children exhibiting extreme behaviors and asked them to put a name and a face and a spirit to the child, they tell a very different tale. Then they feel neither powerless nor despairing. They are challenged, they are overworked, they are isolated and they are angry at the lack of support. We hear all of that. They are stymied by the enormity of the problems they are encountering.

Shifting the language from "these children" to "our children" is always the point of departure for our teacher and parent workshops.

But by turning the discussion to individual children and what teachers have tried and what does and what does not work, suddenly effective and adaptive strategies can be shared. Shifting the language from "these children" to "our children" is always the point of departure for our teacher and parent workshops. Substance abuse prevention education is the focus of the work we do. And we believe in doing this by helping to give each child a voice, whether spoken or drawn or acted out. Listening to this voice is the groundwork of prevention.

A Training Video, Workshop, and Curriculum

As we enter our second year with Project Healthy Choices for special-needs children, we are now developing a training video for use with teachers, parents and other caregivers. We are designing new workshops for the caregivers of special-needs children, and we are adding our findings to the existing Healthy Choices curriculum materials for general early childhood education. The curriculum is a Bank Street-integrated curriculum approach and focuses on four areas: 1) discussions, 2) puppets and dramatic play, 3) drawing and dictation with 4) a particular emphasis on fitting the environment to the needs of the children.

Hands-on Activities

Our work in the classroom involves bringing in puppets and drawing with the children, as well as classroom meetings and use of literature. Through these mediums of expression the children are able to both explore and share their experiences and perceptions relating to drugs and alcohol. Our project emphasizes the moments in a classroom when children are given opportunities to talk about their feelings, their questions and their confusions.

We want children to hear the strength of their own voices. It makes them feel important when a teacher listens to them. It teaches them that what they have to say really matters. We bring puppets in, and through them we elicit information, real stories from the children. Sometimes they are specifically about alcohol, specifically about drugs, about something they have seen in their home or something they

have seen in their neighborhood. Sometimes it is about what it feels like to be angry. When we ask them, "Do you ever get angry at someone in your house?" children invariably have a lot to say.

By using puppets, the children can get angry without retaliation, they do not get punished, they can say almost anything. The children choose their own puppets from a spectrum of generic puppets with different expressions on their faces. As the children play with the puppets we begin to ask questions like, Why do people drink?" The children respond through both language and role-playing. One child said, "They go to clubs and they start drinking and then they don't realize that they have had too many drinks." While a puppet was pretending to drink, a different child said, "I don't want him to hurt anyone." Another young boy talked about how his grandmother had died. He had been teased on the street, so when he got a puppet, he pretended that his puppet had a gun, and he wanted to shoot the other puppets.

At moments like these it is possible to intervene and say, "Can you tell the other puppet that you're feeling sad, his teasing makes you feel bad, and that there's another way other than shooting people?" As children articulate their own feelings, they also get to hear their classmates talk about experiences which may be similar to their own, and is both a learning and sharing experience. It helps them to come out of the shame and isolation they may feel about something happening in their lives, through the recognition that they are not completely alone in the world.

We know children love to draw. Because this is such a potent medium of expression for children, we sometimes ask them to draw pictures about drugs and alcohol. We ask them to tell us whatever they want about the picture and this can mean one word or it can involve a lengthy story. We try to share pictures with the group to affirm that this kind of expressiveness is important and that what the child had to say, what they drew, has real meaning and real importance.

Children also love to have stories read aloud to them, and we are developing a literary component to our classroom project. We read many books, including those that deal specifically with drugs and alcohol. It is thus possible to introduce character-models that have overcome hardships the children may be experiencing themselves. We also try to model for teachers in classroom meetings, the importance of sitting down with children in a different part of the classroom, maybe away from the tables and desks, to simply talk about what is happening at school or to discuss what is happening at home. It is an arena that is quite different from reading and math and other specific academic skills. It is a time when children can just talk.

Helping Children Find a Voice

All of the components to our program serve as ways for children to identify with life experiences that are similar to their own, to feel empowered through their expressions and to realize they are not alone with their problems. It is the goal of our program to explore these mediums and to prepare and educate teachers, parents and ultimately communities to use them as a means of fostering each child's expressiveness.

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"The biggest difference that I've noticed is in the family structure. It's almost as if the middle generation has disappeared. I would say at least 25% of my children are living with either grandparents or other caretakers, and not only are there no fathers, but there are no mothers in the picture".
Mindy Sussman, 1st grade teacher

"They need a lot of attention and love, you know. And a lot of times I can't give him all that he needs, because I'm recovering, you know. I go to meetings and all this stuff. I have no problem helping him. It's just sometimes, being that he's slow, my patience runs out. I lose it sometimes and then I catch myself. I say to myself you gotta have patience because he's not where other kids will be because he's slow."
Marina, mother

The Women and Infants Program: The Family in Focus

Kathleen Fitzgerald, M.S.
Early Childhood Specialist, Women & Infants Clinic Boston City Hospital

The Women and Infants Program at Boston City Hospital is a comprehensive family-focused early intervention program for drug-exposed children, specifically cocaine-exposed children, and their drug-addicted mothers. The principles and strategies of our program were formulated in response to our understanding of the disease of addiction and its outcomes for both parent and child.

Addiction Defined

As a disease, addiction is understood within the context of a medical model with characteristic signs and symptoms. There is also a predictable course of the disease and a predictable outcome of death if there is no treatment. Addiction is defined as a loss of control over the use of a substance and compulsive use and preoccupation with the substance despite consequences. Jailing these women and threatening these women will not change their perspective or alter their course. They need treatment before they can make changes in their lives. It is not about not loving your children. It is not about not wanting to be a good parent. For many of these women, it is about wanting to parent, but not being able to parent. Often these parents were not parented themselves.

Common Characteristics of Drug Addicts

Female drug addicts have certain characteristics in common and live with certain risk factors that may predispose them to use drugs. Most of the women in our program come from families with generations of addiction. They have confronted family violence, drug-related deaths and criminal involvement. They live in poverty. Their academic performance was poor and, for the most part, they had very negative school experiences. They feel low self-esteem. They have a history of sexual and physical abuse. A study that did consistent interviewing of women in drug-treatment programs found that *80 percent of women receiving drug treatment had been sexually abused as children.* These women feel a lot of unresolved grief which they have learned to cope with by burying their feelings; there is a lot of pain inside these women that they have effectively sealed over and self-medicated against by using drugs.

They need treatment before they can make changes in their lives.

Children need to be understood within the context of the risk factors and characteristic problems that affect their drug-addicted mothers. Intervention strategies need to try to break the cycle of family addiction in order to help the child whose experiences are being modeled to a large degree on their family unit. Children are not biologically predisposed to addiction because of their drug exposure *in utero*. But living with their biological families in an environment of addiction will absolutely predispose them to the problems of addiction.

Designing the Program

We kept these issues in mind when we were designing our program. We also knew that addiction engenders disorganized lifestyles and chaotic behavior and that it was impossible for us as professionals to expect these women to keep all of their appointments in all of the various places that they are expected to keep appointments. Often these women are involved with an array of services like social services and welfare and, in addition, they need to keep doctor appointments and attend substance-abuse treatment programs. To have expectations that they were going to be in four or five different places in one week was unrealistic. Based on this information, the Women and Infants Program's primary principle is the one-stop shopping model of intervention. This means we provide a host of needed services in one place and, in our case, in the non-stigmatizing environment of pediatric primary care.

Key Ingredients

The key ingredients of the Women and Infants Program are the provision of pediatric care, child development services, outpatient drug treatment, referral to inpatient services, if necessary, and family planning. The program is hospital-based and it began in 1989 as a pilot project. It is supported entirely by limited private funds. At the inception of our program, we approached 16 women from the hospital maternity ward who had just given birth to drug-exposed babies and 14 of them agreed to join our program.

The birth of a baby is a critical window of opportunity in reaching these women because it represents a new beginning

There is a lot of pain inside these women that they have effectively sealed over and self-medicated against by using drugs.

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and can serve as a motivation for some women to seek help by confronting their denial and their addiction. Giving birth can also represent a crisis because often it means the mother could lose her child to foster care. So the choice for some women may be to join a program or to risk losing their children.

Establishing a Routine is Important

A typical week in the Women and Infants Clinic begins on Monday when the mother brings her child in for regular pediatric care. She may get a developmental check-up, which entails talking about the progress her child has made, discussing activities to do at home with her child, and answering any questions or concerns she might have. We have a toy lending library where the mother can sign out a toy to bring home for her child. The mother also gives a urine sample. Urine screens are expected from these women a few times per week as a way of assessing recovery. On Tuesday the mother comes in without her child and receives individual drug treatment counseling. We also provide couples counseling if there is a partner involved. The mother gives a second urine sample. Life management issues are usually handled over the course of the week — we help the women in our program get housing and we help them with job-training. On Thursdays the mother comes in for a one-hour parent-child group. Fathers are also involved in that group now, which is wonderful. Then the mothers go to a one-hour relapse and recovery group with a substance-abuse specialist while their children are in child care and they give another urine sample. We also do play therapy with older siblings who are not our identified children. Although we focus on the mother-child diad, we are very inclusive of the rest of the family.

Incentives Keep Them Coming

The program has a number of incentives to keep the mothers coming in, and these very practical considerations have gone a long way to help us succeed. We provide free transportation to the program by giving out taxi vouchers and bus passes. We also provide lunch, which is not just a way of filling these mothers' stomachs — it is a sign that we are being

If we can affect positive change in a child's environment then we can improve developmental outcomes for the child and perhaps mediate some of the biological risk factors.

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nurturing of these women. A lot of the activities we do in the parent-child group involve making things that can be taken home. One example of this is a very popular project we did making baby books. We took pictures of the children on an ongoing basis to document their progress and behavior. The mothers arranged these in a book which they decorated and were able to take home.

Appointment Books for Scheduling

To help with scheduling, we have given the mothers appointment books. When we started this program, we had lofty goals about all the intensive work we were going to do with the mothers when they got into the parent- child group. We were planning to offer sensory motor activities that they could take home. We were developing an elaborate curriculum. But what became evident was that we had to figure out how to get these women's lives organized just to get them in and have them keep their appointments. Giving them appointment books was enormously successful (as long as they did not lose them, which some of them did). They really perceived it as an empowering and self-reliant way to help them structure their time.

A Team Approach

Our program uses a transdisciplinary team approach. We use professionals from a variety of disciplines. We work very closely to educate and support each other around our various experiences and strengths so that we can be a truly family-focused program.

As a child-trained professional, having access to a substance-abuse therapist for consultation, supervision and training has been enormously important for me. Similarly, teachers in the classroom should be able to talk to the appropriate professional about what it feels like to interact with a parent who is distant, who is disorganized, who is not able to come in for a meeting. As a teacher in the classroom, when I saw a child in pain or in trouble, I got very angry at the parents. And it is very easy to get angry when you have asked a mother to come in six times, and she says she will and never does. We need to know how to process this

Goals and interventions have to be developed for the whole family because the best way to help the child is to help the family.

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anger because when it gets projected onto the parents, it only serves to further alienate them. By understanding something about these mothers from a variety of perspectives, it became clearer to me why they behave as they do. This understanding helped me to better help them.

A Family Intervention Orientation

The Women and Infants Program also follows the principles of family-focused intervention. Certainly there is a move in education with the special education law, Public Law 99457, to move from child-focused intervention to family-focused intervention, and that needs to happen. This law acknowledges that goals and interventions have to be developed for the whole family because the best way to help the child is to help the family. We can have a great curriculum developed for a child in the classroom and elaborate services plugged in for him but, if the mother cannot get him up in the morning to get on a school bus, then intervention will not work.

We believe and we know through research and practice that if we can affect positive change in a child's environment then we can improve developmental outcomes for the child and perhaps mediate some of the biological risk factors. At the Women and Infants Clinic, we support the mothers, and now the fathers too, in their capacity as parents by giving them tools to successfully parent their child. In many ways we are teaching parents to be parents. Many of these mothers were not parented themselves as children and have had such traumatic histories that they have no sense of what parenting means.

I cannot emphasize enough how hard some of these women's lives have been. We have one mother in our program who, as an eight-year-old, had her two-year-old sibling shot and killed in her arms and another woman who watched the murder of her mother by her father. These are not atypical stories.

One of the mothers came in for her regular pediatric check-up and was asked by the doctor whether she played any nursery games —"peek-a-boo" or "pattycake"— with her child. The mother was quiet and responded sheepishly that,

in fact, she had not. She wanted to, but she just did not know how. She had no confidence that she could do something in a natural way because she was certain she had no skills. This brings into focus what these families are dealing with.

School Can Be a Scary Place

When we conceive of family-focused intervention at the public-school level, traditional contacts like the parent-teacher conferences do not necessarily work for these families. Part of the reason is that school can be a very threatening environment for these women. One mother in our program told us, "You know, the only time I ever hear from the school is when Calvin's in trouble. So I just stopped going." We need to examine the kinds of contacts we have with these families and make them positive ones, otherwise, we will simply turn away the people with whom we need most to form a partnership.

Empowerment

The parents we work with are really involved with our program, which is an empowering experience for them. They are empowering themselves by doing — by investing themselves in their child's program. They are even planning a bake sale to raise money for our project (and we need the money). Our most popular experiences for the mothers are the lunches and the parties we have for them — much less threatening than calling them in for a parent-teacher conference. We also mark celebrations — first-year birthdays and time spent in recovery are important occasions. It is critically important to recognize these milestones of progress with the families because it shows we recognize and respect the struggles of both parent and child to develop to their fullest potential.

Strategies

In terms of our strategies, we have very clear expectations for the mothers. This is critical in working with drug-addicted women in recovery becasue they need and look for very clear limits and consequences for their behavior. Respectfully, I want to compare their steps in recovery to the first steps taken by a toddler. They really want the independence, but they need that independence within the safety and security of limits set by the program. We expect weekly urine screens to monitor their drug use or their clean time. Attendance at group meetings and keeping appointments is mandatory — slipping up might mean involving social services or, at the very least, incurring the wrath of staff. This limit-setting occurs within the context of a therapeutic relationship, and that is critically important so that we do not turn mothers away. Our relationship has taken a long time to build.

A therapeutic relationship is non-judgmental, respectful, empathic and honest. We reach the mother through the baby by showing a genuine interest in the child and a genuine concern for its development. We also connect with the mothers by being flexible in our roles and providing concrete services that they need. If they need housing, we help them get housing; if they need food, we help them get food; if they need a baby carriage, we go out and get them a baby carriage.

This is the beginning of letting them form a trusting relationship with people. Typi-

cally, they have not had positive relationships in their lives. And by doing both practical and nurturing things for these mothers, we introduce them to the possibilities of a trusting and caring relationship. It is our goal that as mothers grow through this relationship they will, in turn, provide a safe, secure and caring environment for their children.

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"She always knew, I guess, when I was going to get high because I'd have a big bag of candy for her. And I'd tell her, 'Go in the room and close the door,' and I'd be in the kitchen. And you know after maybe a half an hour she'll come inside the kitchen and, 'Mommy, what are you doing?' and I'll start yelling at her and tell her, 'Go inside the room and close the door.' You know. And now I'm in recovery, she doesn't talk about these things. She doesn't talk about how it made her feel when she seen me actually sitting there sweat popping down my face, shaking with that pipe in my mouth."

Tanya, mother

"We have the skills to work with these kids but the problem is that we sometimes can not appreciate the increments of success that we see."

Yvonne Green, social worker

Reframing the Debate

Mark Rapoport, M.D., M.P.H.
Health Commissioner
Westchester County, New York

As a nation, we have totally failed to address the question of inner-city poverty. In 1991, things are so bad that this may in fact be a good time for a breakthrough. If not, all the problems that are so deeply and inextricably tied to the culture of poverty will not simply continue to exist; rather, they will be compounded and they will grow.

At this point, poverty has become very complicated, like a cancer patient with a lowered immune system who catches pneumonia — the underlying problem needs to be treated, but at the same time, we have to pay attention to and treat the complications if the patient is to survive. I believe it is the "complications" that have made poverty such a daunting issue. Crack cocaine is one of these complications. To combat it, we must all become politicians, not just educators, pediatricians, social workers or responsible citizens. We must learn to temper our idealism with pragmatism; we must approach change in ways that will allow a broader united front to arise which can, in turn, make the whole nation, not only our audience, become our partners and allies.

Bail or Patch?

One of my favorite analogies for the problem of poverty — or least favorite — depending on whether I focus on its aptness or its implications — is that we are in a leaking boat and we have to both fix the boat and bail at the same time. If you stop bailing, you will sink long before you fix the boat and if you do not fix the boat, you will bail forever. Unfortunately, so far we have done our bailing with a strainer and tried to fix the boat with wet toilet paper. Neither has worked at all well. The twin tasks are difficult to manage, but this is the only boat we have.

In this country, poverty and racism cannot be separated. The reason that the United States and South Africa so often turn up on any given list of bad features is that the poor people are "them," not "us." As a white person it is much easier to tolerate injustices when you cannot easily imagine yourself, your parents or your own children in those terrible circumstances. In addition, our nation still believes in the "frontier mentality," that you pull yourself up by the bootstraps. We expect people to do this and if they do not, it is somehow

their own "fault." On the other hand, the new "politically correct" stance seems to the other extreme. Any mention of flawed behavior on the part of the poor is "blaming the victim" and is beyond the pale of discussion.

The Compassion Burnout

The majority of Americans are also too tired and depressed to focus on issues of poverty at home or abroad. Since Lyndon Johnson, we have funded, although not at a great level, a variety of domestic efforts which do not seem to have made much difference. This has resulted in a real compassion burnout, on both the domestic and the international level. There have been too many Ethiopian droughts and homeless families for people to mobilize for another one, and if we expect to do anything about "that problem" or "this problem," we need to look at these problems in a different way.

There are certainly reasons to think it is not a great time for change. Ronald Reagan did a huge disservice to this country's approach to domestic efforts, and I think Bush may be more dangerous. We have witnessed two awful situations over the last few months which make me think that it may not be that easy to change the tide of poverty. In response to a recommendation to spend $58 million for measles eradication, Bush sent out six study teams to learn anew what we already know about the problem's cause; when confronted with the need to raise approximately $100 million for infant mortality programs — an amount much less than the cost of one B1 bomber — the President tried to take that money from funding for neighborhood health centers.

Still, Things Can Get Better

Despite what we are up against, I firmly believe that things can get better, and now. In part, that is because they have been handled so badly in the past by this country, by our government, that it almost has to be better. Secondly, I think there is a rising fear about the future of our country. Some fraction of that can be attributed to the success of Japan — we are no longer as certain that, as Americans, we can do anything we want and that we will do it well once we put our mind to it. Thirdly, there is a renewed sense of family focus in the country.

These factors make possible, but by no means sustain, a consensus for change. But if we are going to get the consensus we need in this country to make a substantial attempt to overcome poverty, it will take a huge amount of compromise. That compromise will mean both not getting everything we want and also getting things we do not want. I think the "liberal agenda" will not succeed unless a majority of the country believes in it (or at least is willing to give it a try) and is willing to fight for it financially as well as emotionally. Because of this, the core of our program must focus on the protection of children.

Reframing the Problem of Poverty

To get the majority of the country on our side, we have to reexamine the metaphor that poverty is a disease, and the victims have not contributed to their predicament. First of all, I am not sure this is a valid metaphor. There are many recovering addicts who are clearly conquering the problems that were thrust at them. And, unfortunately, this differentiates them from many other substance abusers. Still,

Americans are tired of hearing that everyone is a victim.

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we must use the self-empowerment of those who have succeeded as a constructive model.

The other, more important reason why we have to abandon that particular metaphor is because the country does not believe it. The question of fault is often a sticking point. It is a matter of faith more than a matter of evidence. I understand the trap of blaming the victim, but I think we have to at least tread the line, while being conscious of that risk. Americans are tired of hearing that everyone is a victim. To the extent that the metaphor is 75 percent correct, then it needs to be defended. But it needs to be modified, because the country simply does not believe it.

Perhaps the darkest example of why we must temper this metaphor of the victim lies in the arena of AIDS. Many object when an infant infected in the womb is called "an innocent victim." The implication is that some other victims are not innocent. It is the contention of the groups involved in AIDS activism that *everybody* is equally innocent — the person who frequented high-risk sexual establishments or shared needles even after he or she knew that this put them at risk is as innocent as the little baby who was born infected. Insisting that everyone accepts this as an article of faith is not in and of itself helpful. It may make it impossible to get consensus and may in fact foster resistance to constructive change.

Abandon the Devil Theory

We have to abandon the "devil theory" — the belief that the middle class, politicians and white male Americans are all bad. The cabdriver who passes two African-American male teenagers at midnight on a Saturday can not be dismissed as a "redneck," but must be seen as a victim of racism as well — he or she wants that fare. He is driving past because he is scared and he has reason to be. We have, on the one hand, to recognize the overwhelming problems of poverty and racism, but on the other hand we can not ignore epidemiology. At a time when 25 percent of African-American males in their twenties in New York State are, on any given day, in jail or on probation or parole, there is basis for that fear. And

*The needed changes and their huge cost need to be cast as an **investment** in America's future, not simply as one more expenditure.*

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when we make statements that ignore it, again we lose our audience. And this audience needs to become a full participant if things are going to change.

The first key to arriving at a solution, once we have the consensus we need, is recognizing that the expense will be extraordinary. I do not want to dwell on this. The money is there; it just must be freed up from other less critical programs. We must also listen to the needs of the clients. When I ran a lead poisoning program in New York City, we tried to remove people from a certain lead-contaminated hotel, and they would not leave. We pointed out how important it was for their children's health, and they still resisted. Finally one person said to us, "This place is the safest place I've ever lived. There's a guy who's 6'3" with a big club at his side, and he doesn't let the bad people in." That is what the clients had to say about it. We need to understand that kind of reality, their perception of it, and address it.

An Investment in Our Future

The needed changes and their huge cost need to be cast as an *investment* in America's future, not simply as one more expenditure. And I think it is. Drug abuse is a core problem. In the context of drugs, we need to see an increase in drug testing. We need to get beyond the jargon we hear from some quarters: that it violates the integrity of a person to be tested. Those are not practical approaches. We are far beyond that. Reaching a solution is going to be intrusive. Nobody likes to be intrusive. We all say, "I wouldn't want someone to do that to me." But without an intrusive and sometimes coercive system, we are not going to get out of this. The fact of the matter is that we have lots of people who, although they are victims, are also at this point victimizers. A tough law-enforcement approach will not by itself solve the problem, but no comprehensive plan will succeed without it.

The Need for "Healthy Pragmatism"

These are practical concerns, and many progressives seem unwilling to address practical issues. But we are running a country, and to do this effectively demands a healthy pragmatism. We have

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to look at what works. There are excellent examples of great programs, but they exist at a minuscule level. We cannot forget them, but we need to look beyond them if we are going to tackle this on a larger level.

We have to have comprehensive drug treatment for all. The treatment programs in New York can accommodate only ten percent of those who need it, and only two percent of pregnant women. That is absolutely untenable. It illustrates one of our country's biggest problems in dealing with poverty, and that is the sense of unreality that surrounds it. Thus far, we have been unreasonably and unbelievably shortsighted — people understand the problem exists, but the discount rate (over time and cultural chasms) in their minds is so strong that they will not invest the money. There is a hostility toward the poor and toward minorities so profound that the country and the government seem to be willing to take a loss in order to not help those in need. (As when we underfund prenatal care in the WIC program, which returns two to four times the original investment in decreased health expenses in a year or so.)

Depression an Issue

I think we have to recognize that clinical depression on the level of the individual is very important to this issue. The numbers vary, but up to 40 percent of the women who are in homeless families have a clinical depression and that helps to explain why they do not keep their medical appointments and behave in other ways which do not further their own interests or those of their children. They do not do a thousand things that they really ought to do. I think they want to, but depression is, as the Chinese say (or they used to say), the "key link" in all that.

The Need for Fiscal Conservatism

We need to be fiscally conservative in everything we do. If we are going to get a commitment to the massive investment we need, then we must make sure not to waste one penny of what we get. We need to be rigorous and tough on ourselves, because when critics say, "He wants $100 million but I saw him waste $25 on cab fare," you lose your audi-

ence and your support. And although the funding and the parameters need to be laid out on a national level, the nuances need to be managed on a local level. There will in fact be some triage in all this. That is a word that we do not object to on the battlefield or in the emergency room, and I think it is also unavoidable in this struggle as well. There are some people who are, through faults of their own or through no faults of their own, so far beyond help that we may have to give up on them after we have tried our best and failed. To give up without trying is untenable, but to fail to be realistic is to let the few drag down the many.

Schools: An Important Role

And finally, schools have to play a key role in change. The school, as one of the few relatively intact institutions in our most troubled neighborhoods, needs to be the locus of probably just about everything to the greatest extent that it can be. And yet, New York City is about to dismantle its school health program which was perhaps one of the most basic first steps towards moving in the right direction. The Elementary School Center's "School as Locus of Child Advocacy" initiative recognizes this need — it merits our attention and support.

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Stop the Research, Start the Work

Eric Brettschneider, J.D.
Coordinator, Agenda for Children Tomorrow (ACT)

As part of *glasnost*, a Russian citizen who was encouraged by the spirit of change made a telephone call to find out when his car would be delivered. The bureaucrat he spoke to said the car would be delivered on July 17, 1999. The citizen paused for a moment when he heard the news and asked, "In the morning or afternoon?" When the bureaucrat asked "Why?" he responded, "Because in the morning the plumbers are coming."

In another reference to the changes in that part of the world, a farmer who lived on the border between Poland and Russia was approached by a surveyor and told, "We just surveyed your land and you are no longer part of Russia. You are now officially a part of Poland." The farmer paused for a moment and said, "Thank God, I couldn't have stood another Russian winter."

There are some implied warnings in these anecdotes, because like the changes initiated by *glasnost*, in some cases rhetoric and form seem to overpower substance in the child care revolution that is happening today in the United States.

A Study of the Studies on Children and Services

Not too long ago I was asked to do a study about children in New York City, and I indicated that was not something I wanted to do. Instead, I agreed to research all the studies that had already been done over the last ten years to see what they had recommended and what had ultimately become of them. To meet our research criteria, a recommendation needed to have a subject and a predicate. It needed to be specific and clear enough in its intent that it could be directly implemented. It had to include dollar cost. It had to show the capacity to evaluate its findings. Each recommendation had to say how, where, why, how much, and when.

But too often the recommendations we read were "Somebody ought to do something about children and substance abuse" or "There ought to be a central authority" or "There ought to be a greater authority" with neither the level of detail nor the practicality that we were looking for.

In some cases rhetoric and form seem to overpower substance in the child care revolution that is happening today in the United States.

The Ritual Call for Decentralizing Services

In the reports we read, one recommendation kept returning — the need to decentralize services — so that the language of each of these recommendations became almost ritualistic. They would call for decentralization, but not just mere co-location, with service integration and so forth. We saw reports that called for czars for children over and over again despite our experience, or at least my grandparents' experience in Russia.

Then the titles would shift, and the czar would become a deputy mayor. But the responsibility of a deputy mayor seemed to change with each administration, when somebody new came along that played the game differently and changed the responsibilities of the person now called the deputy mayor one more time.

The recommendations did not reveal a clear sense of neighborhoods. Willy-nilly bureaucracies were reorganized without necessarily impacting at all on the people and neighborhoods at issue. To this day in New York City, people are asking, "Should we split up the Human Resources Administration?" "Should we combine it?" "Should we go through some cycle with the agencies that comprise it, that we have gone through once before?" And the answer continues to be, if we look closely enough, these are not the significant issues. They are merely the issues that keep the debate raging and keep dead-ending recommendations because the constantly shifting language obscures the fundamental issues at stake.

Services: What, Where, and for Whom

We must first find out what services we do have and where we have them and then decide what is wrong with the way we deliver those services to the people in need. We must locate the funding streams and the categories of funding that block our way. And then we should worry about the semantics of jurisdiction, the reorganization of bureaucracies and the fine points to title-bestowing.

In 1975 there was a case study where 28 agencies tried to help a single family over a two-year period. The initial prob-

lem was child neglect with several children involved. There were over 58 professionals, case workers, child care workers, human service workers and guidance counselors, some of whom, it should be said, were not duplicative or redundant.

This was not a simple system for that family to cope with, especially when there were days where not one of these organizations could help them. Maybe they were too old or too young or had exhausted their money or were earning too much money or had been out of work too long or not long enough. It makes you wonder when you look at that situation, and you juxtapose it to the $2.5 million spent in the Borough of Queens to fund all their meetings on the need to coordinate.

The Police Precinct: A Model to Consider

Studies appear every day in the paper talking about the connection between how child abuse causes teen pregnancy, causes runaways causes violent criminals. These correlations have been uncovered and labeled over the years, but all the work and money is spent diagnosing the problem. There is very little left to go towards solving the problem. Keeping in mind the role-reversal and body-switch movies of the last few years, the film I want to see is the social service agency that wakes up as the police department and the police department that wakes up the very same day as the social service agency. Whatever is right or wrong with the police, "911" is a pretty good number to dial if you are in trouble anywhere, certainly compared to some other numbers that we dial. And a local precinct works pretty well in New York City if you want to know where to go to access the system.

A few years ago, a group of people began a project called "Agenda for Children Tomorrow." They began to think about this kind of body switch. They wanted services to be easier to find, easier to use and responsive to need. They wanted neighborhood-based centers and co-location of services. World War II could not have been fought without mentioning beachheads by name, but for so long we had been talking about bureaucracies and phenomena and problems in a very impersonal way and not about the people in need and the communities they lived in.

With the recent fiscal crisis people began to question what could be done with so little to do it with. I think we have to return to the resources we have and work to salvage those — and we have to remember that in many cases at least, our families listen. If we work to salvage our nation's families, then we will have a close and supportive unit ready and able to respond to the needs of its members.

Collecting Data Neighborhood by Neighborhood

We are meeting in task forces now in New York. And we have met before, but this time we are gathering information neighborhood by neighborhood. We are not just talking about co-locating or relocating services. We are finding out where they are already located and who uses them, how the space is used within buildings. We are looking at the total context of all the agencies, whether they are in the mental health area or in the child welfare area—from the users' perspec-

If we work to salvage our nation's families, then we will have a close and supportive unit ready and able to respond to the needs of its members.

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tive. We want to know whether a so-called drug-treatment "slot" is in fact a methadone slot which is inappropriate for the crack-using client we have in mind. We want to know if young people or pregnant women are welcome to use this slot. This is some of the basic information that we have not had. We will be working with local groups and with the state looking for the connections that can be made.

We will be using the power of the mayor and his endorsement and his commitment and the power of the foundations that are backing us up to take this vision, to gather the information, and then to do something other than hold hearings where people get the mere opportunity to be heard. We will be involving people through focus groups, which is a corporate principle I think government can learn from, to really find out what we want to know, to get answers to questions we truly wanted to ask. And we will work to establish and to empower local groups to carry on this activity in an ongoing way.

Do You Know Everybody?

At some point my son asked me what I did for a living and I told him I was the director of a nonprofit, multiservice, comprehensive, social service agency in Queens that handles child abuse. He understood something about child abuse and my role in stopping it and so he asked me, "Well, do you know everybody in Queens County?" But I'm not so dumb. I said, "I don't know everybody in Queens County, but we have 100 staff members and 100 volunteers." He paused for a minute and looked at me and said, "Do they know everybody in Queens County?"

My son taught me something then about unreasonable expectations and reasonable expectations. As we approach this project, I have tried to think that we start with his kind of expectations, whether you call them reasonable or unreasonable. We must begin to make manageable units in this huge and complex system that defies us all, let alone the people who must behold it for the first time. We must try to make these units accessible to everyone.

Through this process — and it is a revolutionary one I think — of learning to reach out with what we have — I have begun to think and hope that someday we will reach — as my son expected — every child in need, and that this vision is less distant from us than it was before.

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"I think what happened is that the problem seems so overwhelming that we feel that everything is out of control, just like the parents do. They feel things are out of control. The kids come to school and they feel there's very little they can learn or do or very little they can be successful in. So the feeling of helplessness paralyzes all three groups to the extent that we can't do what can be done."
Yvonne Green, social worker

RECOMMENDATIONS: AN AGENDA FOR ACTION

The following recommendations represent the consensus of the educators, administrators, researchers, social service professionals, and policymakers who attended ***EDUCATING CHILDREN FROM THE WORLD OF CRACK: Myths & Realities Concerning Children Prenatally Exposed to Drugs & Alcohol,*** July, 1991.

At the invitation of the United States House of Representatives Select Committee on Narcotics Abuse and Control, these recommendations were presented at a hearing on the July 30, 1991, regarding "Drug-exposed Children in the Schools: Problems and Policy." These recommendations are proof that *we really do know what to do* — we must now demonstrate that we have the will to do it.

Recommendations for Educators

- Schools have increasingly taken on a stabilizing role in children's lives, so schools must be enabled to do by design what we currently expect them to do by default. They must also become the locus of child advocacy because *schools are where the children are*.

- Schools must begin to acknowledge the role of the family as co-educator and learn to work more effectively with families.

- Legislators should fight the temptation to divert money from regular education to special services for the drug-exposed. Instead, more funding — or at least more flexible funding — must be available to improve the educational process for all students.

- The Head Start model should be expanded down to birth and up through sixth grade, always emphasizing prevention and the family. This would include:

  - Parent training, self-assessment and development;
  - Small class sizes;
  - Developmentally appropriate practices;
  - Home-based interventions and support which strengthen the bonds developed among teacher, parent, caregiver, and child;
  - Consultation opportunities through built-in resources such as health, social and nutrition services.

- Elementary school and Head Start teachers must be helped to identify the causes of stress in children's lives and then be provided with necessary supports so those problems can be addressed.

- Schools should become more of a community resource. There should be tutoring, recreation and job training available.

- More in-service training on addiction must be available to teachers and principals if they are to both identify the problem and work with families so affected.

- Incentives must be provided for staff development, in-service and pre-service training and education for staff who commit to working with children and families at risk. Incentives would include forgiveness of loans or low-cost tuition for additional training.

- The Federal Government should provide support and technical assistance to all states, keeping them up-to-date on how different states are funding special and regular education programs and training opportunities.

- Interventions for all special-needs children must begin at birth, not only by tracking them, but by providing enriched educational opportunities.

- There must be better coordination between those systems serving children from birth to three years and those serving children from three to twenty-one.

Recommendations for Social and Health-related Services

- More culturally sensitive services should be provided in the community — from parenting instruction to child-development training to nutrition counseling.

- Community-based "Human Resource Centers" should be created to provide information on prenatal and postnatal care and the effects of parental drug use on the unborn as well as on all children.

- More home-based interventions must be developed because they are more effective and less threatening to parents; home-based interventions are especially effective when child-focused strategies are taught to parents and caregivers.

CONCLUSION

In some ways, addressing the needs of THESE CHILDREN/OUR CHILDREN presents an opportunity. It compels the formation of active, working partnerships across the spectrum of child-serving professions — a good practice to apply for *all* children. Furthermore, the educational challenges presented by THESE CHILDREN/OUR CHILDREN compel a search for their strengths and skills, to build on them by developing individual learning and teaching strategies — which again, we ought to be doing for *all* children.

Children prenatally exposed to drugs and alcohol are special because they are acutely vulnerable; a growing population of school-aged children suffer the double jeopardy of prenatal drug or alcohol exposure and the misery of growing up in a drug-abusing environment. THESE CHILDREN/OUR CHILDREN have been placed at risk biologically, developmentally, socially, emotionally, academically and, often, economically. The odds are stacked against them. To address this disparity, society must summon the best it can offer to improve their odds, so they can grow up to be productive and contributing citizens.

It is too late to be proactive for hundreds of thousands of THESE CHILDREN/OUR CHILDREN and their families. The terrible consequences and crippling costs in human, social and economic terms are already painfully obvious. Yet it is not too late to be proactive for the subsequent legions of children who will continue to be at profound risk if policies are not enacted and initiatives are not begun that can reverse this social malignancy.

Despite their often cruel handicaps, THESE CHILDREN/OUR CHILDREN are not necessarily doomed. Many dedicated professionals are devoting themselves to developing effective strategies. They should inspire all child-serving professions to work together for a sense of national commitment to THESE CHILDREN/OUR CHILDREN — America's most vulnerable citizens.

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"I was given hope because I listened to a physician and the physician said that if we get them soon enough they can make it. But we need those facts, we need research. Let us know what's really happening in their brains and in their bodies, and with more facts — at least we have a chance."

Ina Weisberg, kindergarten teacher

APPENDIX

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Thousands of drug-exposed babies are now of school age, presenting schools and educators as well as social service agencies with enormous challenges.

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- **BOOK**
  NEITHER DAMNED NOR DOOMED: Educating Children Prenatally Exposed to Drugs & Alcohol

These materials can be purchased separately or as a package. For more information, contact the Elementary School Center at (212) 289-5929.